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A Qualitative Study of Mental Health Nurses' Experiences of Patient Suicide or Unexpected Death and its Aftermath

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A Qualitative Study of
Mental Health Nurses' Experiences of Patient Suicide or Unexpected
Death and its Aftermath

Oliver Shanley

Research Based Thesis

Submitted for the degree of Doctorate in Health Care

Florence Nightingale School of Nursing and Midwifery

Kings College

London

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Abstract

There has been an absence of research that explores the combined effect of experiencing a patient's suicide or unexpected death and the subsequent process of professional scrutiny that frequently follows such a death.

This is a qualitative study utilising constructivist grounded theory that explores the experience of fifteen mental health nurses from four NHS trusts and their response to a patient suicide or unexpected death. The study considers how the death and the resultant process of professional scrutiny affected the nurses both professionally and, for some, personally. This research is placed within the context of what is known regarding the effects of professional scrutiny, the psychological impact of adverse events, and the broader concepts of responses to adverse events referred to as 'second victim' phenomenon (Wu and Steckelberg 2012).

The findings of this study identified several areas that demonstrate the impact of an unexpected death or suicide on the nurses. The participants all experienced varying degrees of psychological distress, which for two were similar to experiences more normally associated with post-traumatic stress disorders. The psychological response to the distress of the death and process of scrutiny was similar to that found in second victim studies. However the nurses in this group did not believe they had made an error, often a factor associated with second victim studies.

The study found that the type of relationship with the service user is an important denominator in determining how the nurse reacts to the death. The process of professional scrutiny further compounds this. Nurses' report that they are unable to find psychological closure until the scrutiny, particularly the coroners hearing, has concluded.

The study identified a number of factors that are likely to aggravate or mitigate the likelihood of experiencing an adverse psychological effect from an unexpected death or suicide. A distinct contribution of this study is the development of a theoretical framework that may aid the understanding of the experiences of the nurse. The study concludes with recommendations for further research.

CONTENTS

	Page N ^o
ACKNOWLEDGMENTS	10
CHAPTER 1	
BACKGROUND AND OVERVIEW OF THESIS	11
1.1	11
Introduction	
1.1.2	12
Research context	
1.1.3	14
Policy context of mental health care	
1.1.4	16
Blame and scrutiny	
1.1.5	17
Prevalence and impact	
1.2	19
Structure of thesis	
1.3	20
Conclusion	
CHAPTER 2	
OCCUPATIONAL STRESS AND THEORIES OF	
PSYCHOLOGICAL STRESS AND TRAUMA	22
2.1	22
Introduction	
2.2	23
The consequences of occupational stress	
2.3	24
Theories of stress	
2.4	29
Coping mechanisms and factors that mitigate stress	
2.4.1	30
Personality factors	
2.5	32
Trauma	
2.5.1	35
Secondary trauma and second victims	
2.6	38
Conclusion	

		Page N ^o
CHAPTER	3	UNEXPECTED DEATHS AND PROFESSIONAL SCRUTINY – A REVIEW OF THE LITERATURE
		40
	3.1	Introduction
		40
	3.2	The nursing literature
		41
	3.2.1	Summary of nursing literature
		43
	3.3	Psychological effects on employees
		43
	3.4	Relationship with the deceased
		49
	3.5	The inquiry and investigatory process
		51
	3.6	Blame and accountability
		58
	3.7	The employers response
		61
	3.8	Previous experience
		63
	3.9	Summary of current knowledge
		65
	3.10	Conclusion
		67
CHAPTER	4	METHODOLOGY
		69
	4.1	Introduction
		69
	4.2	Research aims and objectives
		69
	4.3	Research design and methodological considerations
		71
	4.3.1	Sample and sites
		74
	4.3.2	Preliminary work for interviews
		76
	4.3.3	Involvement of participants
		77
	4.3.4	Methods and Data analysis
		78
	4.4	Methodological rigour
		80
	4.4.1	Transparency
		81
	4.4.2	Descriptive vividness
		81
	4.4.3	Repeatability
		82
	4.4.4	Analytical, theoretical and heuristic relevance
		83
	4.4.5	Reflexivity
		83
	4.5	Ethical issues and research governance
		84
	4.6	Conclusion
		85

		Page N ^o
CHAPTER	5 FINDINGS	86
	5.1 Introduction	86
	5.1.1 Summary of findings	87
	5.2 Characteristics of participants	87
	5.3 Section 1	
	The psychological and social impact of the unexpected death or suicide of a client and its aftermath	89
	5.3.1 Introduction and synopsis	89
	5.3.2 The immediate response to the incident	91
	5.3.3 Reactions to hearing the news of the death - the need to understand	95
	5.3.4 Reactions to hearing the news of the death - impact on staff	98
	5.3.5 Summary	100
	5.3.6 The consequences of the incident and the subsequent process of scrutiny	101
	5.3.7 Summary	111
	5.3.8 Relationship with the service user	111
	5.3.9 Summary	117
	5.3.10 Relationship with the family of the deceased	118
	5.3.11 Summary	124
	5.4 Section 2	
	Factors that make nurses either, more, or less susceptible to experiencing an adverse psychological response	125
	5.4.1 Introduction and synopsis	125
	5.4.2 Supportive factors	126
	5.4.3 Summary	131

	Page N ^o
5.4.4 Psychological preparedness	134
5.4.5 Summary	136
5.4.6 Organisational blame and professional scrutiny	137
5.4.7 Summary	140
5.5 Section 3	
The impact of the death and its aftermath on the mental health nurse's practice	141
5.5.1 Introduction and synopsis	141
5.5.2 Record keeping	142
5.5.3 Summary of record keeping	146
5.5.4 Risk assessment and management	147
5.5.5 'Did I miss anything, could I have done more?'	147
5.5.6 Summary	151
5.5.7 The impact of clinical practice	151
5.5.8 Summary	154
5.5.9 Learning lessons	155
5.5.10 Summary	157
5.6 Conclusion	158
 CHAPTER 6 DISCUSSION AND REFLECTION	159
6.1 Introduction	159
6.2 Summary of key findings and the context of the research	160
6.3 Discussion of main findings	161
6.3.1 The psychological experience arising from the death	162
6.3.2 Error and its significance	165
6.3.3 Previous experiences and the relationship with the client	167
6.3.4 Relationship with the family	169

		Page N ^o
	6.3.5 Organisational support	170
	6.3.6 Professional scrutiny	172
	6.3.7 Changes in clinical practice	176
	6.3.8 Learning lessons	178
	6.4 Description of key events and the development of a theoretical framework	179
	6.4.1 Time point 1	
	The incident and the aftermath	181
	6.4.2 Time point 2	
	Interactions with the family	183
	6.4.3 Time point 3	
	Internal scrutiny	184
	6.4.4 Time point 4	
	Coroner's hearing	185
	6.5 Summary of discussion and contribution to knowledge	187
	6.6 Implications for practice	189
	6.7 Reflections on methods	191
	6.8 Implications for future research	193
	6.9 Conclusion	195
CHAPTER	7 CONCLUSION	196
Appendices	1 Methodology for literature review	198
	2 Invitation to participate	201
	3 Participant information sheet	202
	4 Interview guide	207
	5 Example of Theory Development and Transparency	210

	Page N ^o
REFERENCES	212
TABLES	
2.1	Payne and Horne stress framework 27
2.2	Overview of Stress Models 28
3.1	Gustavsson and MacEachron's Model of impact of death 45
3.2	Wright et al's Four factor vulnerability model 46
3.3	Regehr – contributory factors to personal distress 57
3.4	Rallings' organisational support for police officers 62
5.1	Characteristics of the respondents 88
A	Key word search 199
B	NHS policies 200
FIGURES	
3.1	Regehrs' model of police responses 54
3.2	Summary of current knowledge 66
6.1	Framework for key time points 186

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CHAPTER 1

BACKGROUND AND OVERVIEW OF THESIS

1.1 Introduction

Within mental health services some service users will not only reject treatment and intervention but, in extreme cases, will seek to take their own life through suicide or behave in such a way that is high risk and leads to a premature or unexpected death. This study concerns the experience of fifteen mental health nurses and their response to a patient suicide or unexpected death. The study considers how the death and the resultant process of professional scrutiny affected the nurses both professionally and for some, personally. In the context of this study professional scrutiny relates to internal or external inquiries that examined the clinical practice of the nurse. These inquiries amounted to both NHS Serious Untoward Incident investigations and Coroners hearings.

This chapter will establish the context for the study which includes an overview of mental health services and the national policies that shape the organisational climate that mental health nurses work within. As a Director of Nursing within a Mental Health NHS Foundation Trust this research is undertaken through the auspices of a clinical doctorate and against a national backdrop of increasing professional scrutiny for nurses. This research is placed within the context of what is known regarding the effects of professional scrutiny, the psychological impact of adverse events and the broader concepts of responses to adverse events referred to as ‘second victim’ phenomena (Wu and Steckelberg 2012). The chapter will conclude with an outline of the structure of this Thesis.

1.1.2 Research Context

It could be argued that at no other time in history have public servants been subject to a greater sense of accountability and routine scrutiny (DOH 2010). This forms part of a greater societal awareness about what is expected from those who are paid out of the 'public purse'. The present Coalition Government place great emphasis on the 'Big Society', (Cabinet Office 2010) a philosophical perspective calling for a greater sense of collective social responsibility and accountability. From a public policy perspective this is witnessed through the NHS White Paper (DOH 2010), which affirms the importance of professionals being appropriately held to account for providing high quality care. Further illustration is the public inquiry into Mid Staffordshire NHS Foundation Trust (DOH 2010), which established within its terms of reference, the need to understand why there was a general failure of both the organisation and individuals to be held to account for alleged poor performance. The direction of travel would appear to acknowledge that public servants would continue to face a level of scrutiny for their performance, particularly when events are thought to have been of sub optimum standard. It is the experience of the people involved in this type of process and the psychological consequences with which this study is concerned.

The links between occupation and the psychological stressors that can occur as a result of either the direct or indirect consequences of the 'employees' role and role stressors have been documented in a number of texts (Regehr 2003, DOH 2009). There are a relatively discreet group of professionals, who face severe adverse situations as a result of their employment. Their role may expose them to extreme and, in some circumstance, sometimes un-expectedly fatal consequences for the 'client' group they work with. It is this group of individuals and their experiences where there may be a unique opportunity to broaden the understanding of the

psychological and emotional impacts on health care staff and specifically, in the case of this study, mental health care.

Mental health personnel provide clinical services within a climate of increasing expectation of patient safety and public confidence. It is suggested that this pressure places undue stress and burden on staff (Morral 1999). Elfering and Grebner (2011) affirm that greater attention must be given to occupational stress and its relationship with patient safety. Wu and Steckelberg (2012) also reiterate the potential adverse psychological consequences for staff following patient safety incidents.

A number of studies have considered the effects of suicide on various professional groups (Chemtob et al 1988, Fairbairn 1995, Valente and Saunders 2002, Ruskin et al 2004, Gilje et al 2005, Gitlin 2006, Tillman 2006) although few have focussed specifically on mental health nurses. These studies usually demonstrate a range of professional and personal reactions to the incident. These include: distress; guilt; anxiety; anger and a hyper-vigilance towards risk assessment and risk management. Farrington (1995) and Cutcliffe et al's (2006) identify, however, that little has been written on the effects of suicide on nursing staff. Those studies that include reference to nurses (Long and Reid 1996, Valente and Saunders 2002, Valente 2003) adopt a broad approach to the overall impact on nurses. They pay little attention to how nurses cope with the experience of working with someone who has subsequently committed suicide. Furthermore studies, that consider effects on nurses, focus on the immediate aftermath and do not take account of potential on-going effects. This is a striking omission given nurses will routinely be asked to give an account of their professional actions in the routine inquiries that follow in the months after a death.

The national policy direction on clinical risk assessment and risk management is developing an evidence base that will place demands and expectations on preventing suicide and unexpected deaths in 'high risk' patients (Appleby et al 2006, DOH 2007). The consequences of these additional expectations ultimately permeate to

clinical practice through a sense of increasing levels of accountability to prevent adverse events occurring. Ultimately though, incidents do occur and there is an absence of literature that considers how nurses respond and cope with the effects of patient suicide and unexpected deaths when confronted with increasing levels of professional scrutiny. This includes providing evidence to the coroner's court and other forms of post incident inquiry.

This study considers how what is known regarding the personal and professional impact of professional scrutiny and psychological trauma on those working in the broader 'public sector', can be used to understand the experiences of mental health nurses who have worked with a client who commits suicide or dies prematurely as a result of risk behaviours. The definition of 'public servant' includes those roles associated with caring for and within the community, plus a wider perspective that encompasses those groups who have a responsibility for social control and defence of the state.

This study uses the wider literature on work related stress, psychological trauma and the concept of 'second victims' to inform the understanding of the experiences of those who are subjected to professional scrutiny following a suicide or unexpected death.

1.1.3 Policy context of mental health care and patient safety

This section provides a brief overview of the various policies that are influencing mental health practice. It is not intended to provide a detailed analysis of all national policies merely to provide a summary that will enable the reader to understand the context that mental health nurses are working within. The section also outlines the

process that takes place after a serious untoward event including, in the context of suicide, the role of the coroner in the inquiry process.

Over the latter stages of the 20th century there was an increasing recognition that the provision of mental health care which was largely hospital based was insufficient and inadequate to provide meaningful and therapeutic interventions to all but the most seriously ill. Even those clients who required in patient care were often subject to services that failed to meet even the most basic of their needs (Sainsbury Centre for Mental Health 1998, Mental Health Act Commission 2008). In recognition of these operational vulnerabilities the Department of Health began to remodel mental health services with a greater emphasis on the provision of community based services (DOH 1999). This has seen the gradual reduction of inpatient care and the development of new service models such as Assertive Outreach teams and Crisis and Home Treatment services (DOH 2000d). These reforms were placed within what was believed to be the best available evidence that emerged from such agencies as the National Institute for Mental Health in England (2006).

Within the context of the transformation of services there was increasing expectation to ensure that public and patient safety was considered paramount in the provision of health care (National Patient Safety Agency 2006, 2008). In mental health services there is an ongoing recognition that clinicians must pay specific regard to risk assessment and risk management (DOH 2007). Some commentators argue that this emphasis on risk places an undue burden and unfair expectation on clinicians, particularly mental health nurses (Barker and Buchanan-Barker 2005). Nevertheless the Department of Health continues to maintain clear performance indicators on risk and specifically the reduction of suicide (DOH 2006, Appleby et al 2011). Morral (2004) in an overview of the United Kingdom's mental health policy argues the expectations of these policies overburden the existing infrastructure. He points out that the main casualties of this approach are patients and front line staff, with an inappropriate emphasis on risk assessment, a lack of therapeutic risk taking and an ill

considered approach to recovery, all equating to an unrealistic and inadequately resourced mental health service.

1.1.4 Blame and scrutiny

The interim report of the NHS Health and Wellbeing review (DOH 2009) identifies how poor health and wellbeing in staff has a detrimental impact on the three dimensions of quality, namely patient safety, patient experience and the effectiveness of patient care. The report (DOH 2009) states that NHS employees have higher levels of sickness than their peers across the public sector, experience very high levels of stress and often feel that senior managers do little to address these issues. The report affirms that NHS employees are exposed to situations that are often outside the 'usual' experiences of the wider community and these pressures can have a detrimental effect both on their personal and professional lives. This often arises from the impact of cumulative effects of stressful incidents (Tattersall et al 1999, Wu 2012).

The Department of Health (2009) acknowledge that the NHS has to make significant improvements in how it addresses the stress experienced by staff and identifies a blame culture as one of the predisposing features of some of the current practices within NHS management. This culture of blame has been identified across the whole NHS but in the context of this study is also relevant to the field of mental health services. Appleby (2007) in a review of suicides considers some cases that are deemed to be the 'most preventable'. He suggest that there remains a pervasive view among some staff that deaths are inevitable and that this view is unhelpful when developing a culture of safety. The document suggests that this view may stem from a criticism of services when things go wrong, a culture that stems from one of blame rather than understanding. The Confidential Inquiry sets down a challenge for services and advocates that (page 17);

“if mental health staff are to give up a culture of inevitability it is up to commentators outside of clinical practice to give up the culture of blame”

A culture of blame is one frequently referred to when investigating serious untoward incidents (NPSA 2006). Mental Health NHS Trusts are required to undertake a full and comprehensive review of serious incidents, establishing the root cause of why the incident occurred (DOH 2007). In the cases of suicide or unexpected deaths, the organisation's internal review is often the preamble to the coroner's court where staff are again asked to recall their role in the events that lead to the client's death. When a patient, under the care of mental health services, dies in unexpected or suspicious circumstances the law dictates that a coroner must determine, how, when and where the person died. Historically the evidence was ordinarily the sole province of the medical team, generally the consultant psychiatrist. It is now relatively common however, that with the expansion of the nurses role, mental health nurses are asked to attend court. Calthorpe and Choong (2004) suggest that, for mental health professionals, this experience can exacerbate feelings of blame from both within the NHS organisation and from external agencies.

1.1.5 Prevalence and impact

Foley and Kelly (2007) suggest that at some stage most mental health workers will experience the death of a patient through suicide. Given the known prevalence of suicide and the links between suicide and mental ill health it is therefore well established that inevitably those working within mental health services have an increased likelihood of clinically working with someone who may take their own life. Collins (2003) states that suicide is an occupational hazard for clinicians. He suggests that some 5000 to 10000 clinicians will lose a patient to suicide each year. Despite this, it is suggested that death is still a relatively rare event for most mental

health services and particularly so for those working within in-patient services. Bartels (1987) outlines that for many mental health workers the suicide of a patient can have a devastating effect on their emotional wellbeing and be an immense source of personal and professional distress. He suggests that this is particularly profound as predominantly mental health services are focused on preventing deaths occurring, therefore staff rarely have the opportunity to ‘master’ the impact of the death itself. He concludes that;

“The repetitive threat of an event without its actual experience is more likely to produce anxiety about its mastery”

In essence, he is suggesting that due to the relative unfamiliarity of experiencing death, mental health professionals are less prepared for these events than other areas of healthcare. This assertion may offer some insight into the experiences of mental health staff that lose a client to suicide and it is within this context that this thesis explores the experiences for mental health nurses associated with suicide or unexpected deaths.

It is clear that mental health services have changed dramatically over recent years. As part of this transformation, improvements in managing risk have seen a reduction in the levels of suicide and unexpected deaths. However there remains concern about the impact on staff regarding the increasing public and regulatory expectations and moreover how staff feel they may be subject to blame following an adverse event.

What this indicates is that it is probable that mental health personnel are likely to be exposed to a suicide at some stage in their career. However there is little evidence that the nursing literature has considered the experiences of nurses after such a death. Specifically the literature does not include how individuals respond to the professional scrutiny that surrounds the death. I am concerned about this omission and this study will identify how nurses experience a death and the subsequent process of scrutiny.

1.2 Structure of the Thesis

Chapter 2 outlines what is known regarding occupational stress and the resultant psychological trauma including second victim phenomena and burnout in the public sector. It acknowledges the main theories of the impact and consequences of psychological distress and then considers how this study can use these theories to place and understand the experiences of participants. The chapter identifies the main theories that explain how reactions to stress can be mitigated. Chapter 2 also considers where psychological trauma sits among a continuum of psychological stress and draws both upon theories of Post Traumatic Stress Disorder (PTSD) that emerged from the experiences of those involved in warfare, and more recent evidence published by NICE (2005). This chapter considers PTSD in some detail as it sits at the most severe end of the spectrum of psychological responses associated with stress and is important to have an understanding of this in the context of this study.

Chapter 3 deals specifically with the empirical literature that this study draws upon. The paucity of nursing research provided an early indication regarding the need for this study. The first part of the chapter presents what is known to date from the nursing research. However to provide greater breadth outside of mental health nursing and healthcare, literature was scrutinised from a diverse range of ‘public services’. Unexpected events and untoward deaths are common outside of the NHS, as are inquiries and internal reviews that scrutinise the events that led up to the incident. Utilising a common language for the literature search it identifies diverse studies that, when critically analysed, can be divided into six keys. Each theme is discussed within the chapter and utilises various studies to ensure the thesis is cognisant of a broader academic evidence base outside of health. Chapter three concludes with a synopsis of what this diverse literature is suggesting and develops a framework to present the diverse findings from these studies.

Chapter 4 describes the research design and methodology utilised for the study. A rationale is provided for using a grounded theory approach to this qualitative study.

Chapter 5 sets out the findings of the study and articulates the experiences of the participants and emergent theories.

Chapter 6 discusses the findings of the study in relation to previous research. The chapter then discusses implications for practice including the development of a potential guide for staff regarding the timings of supportive psychological interventions. The section identifies areas for future research. The chapter concludes with a critical reflection of the methods used throughout the study.

Chapter 7 concludes the thesis. The chapter provides a brief summary of the overall thesis and sets out some concluding remarks.

1.3. Conclusion

This chapter has provided an overview of the context of this study. There are increasing expectations that public servants should be held to account when unexpected events occur. In mental health services this is seen most obviously through the unexpected death or suicide of a service user. Exposure to such incidents, although thought to be rare, remains a real possibility given the nature of mental health services.

There is an absence of research that examines the experiences of mental health nurses and how they respond to such tragic events. We know that there are likely to be some immediate psychological effects following the death. We do not know however if these effects are long lasting and how nurses experience this. We also do not know if the experiences of the professional scrutiny affect the individuals

involved. This study redresses this and starts to develop an understanding of the experiences of nurses to suicide and unexpected death. In order to develop this understanding the study interacts with the relevant literature that considers trauma, second victim phenomena and the effects of professional scrutiny.

CHAPTER 2

OCCUPATIONAL STRESS AND THEORIES OF PSYCHOLOGICAL STRESS AND TRAUMA

2.1 Introduction

To aid the reader I have approached the relevant literature in two ways. This chapter provides an overview of theories of stress and psychological trauma. This is particularly relevant to this study because it is important to have an understanding of the theoretical context of any potential psychological experiences of the participants. Chapter 3 will address the empirical evidence in relation to professional scrutiny and the experiences of employees across a range of occupational groups. The chapters are structured in this way to provide the reader with an overview of the theoretical basis of psychological stress before one considers the relevant studies in detail. Chapter 2 is not intended to provide a detailed analysis of the theories, merely to enable the reader to gain an insight into theoretical components of stress and trauma. Appendix 1 provides the methodology utilised within the literature search to facilitate a contemporaneous and comprehensive analysis of the literature in relation to both chapters 2 and 3.

This chapter will set out why it is important to understand the impact of occupational stress. It will then provide a brief outline of theories of stress and associated coping mechanisms. The chapter provides an insight into the types of psychological reactions to stress including Post Traumatic Stress Disorder (PTSD) and what is known regarding Secondary Trauma and ‘Second Victim’ phenomena.

2.2 The consequences of occupational stress

Studies that have considered occupational stress are diverse and cover a vast array of areas including but not limited to; political violence in Northern Ireland (Lyons 1974), major industrial disasters (Baum et al 1983), law enforcement (Gersons 1989), natural disasters (De La Fuente 1990), social work (Gustavsson and MacEachron 2002) and those who work in emergency services (Regehr and Bober 2005). The Health and Safety Executive (2009) estimate the cost of work related stress to be around four billion pounds per year, estimating that thirteen and a half billion working days were lost to stress in 2007/2008. They emphasise that all employers have a legal duty to assess the propensity of work related stress and psychological harm and take action to guard against it.

The Department of Health (DOH 2009) identified how 10.4 million working days are lost to sickness absence from NHS employees alone. They suggest this equates to 45,000 staff or 4.5% of the workforce. They estimate that the cost of this sickness absence is £1.7 billion per year. This study also identifies that NHS employees reported higher levels of absenteeism for anxiety, burnout and stress than other workers in England.

The impact of burnout and stress has also been well documented with a suggestion in some studies that whilst health care staff can maintain a focus on task, the ability to 'care' diminishes (Leiter et al 1998, Bowers et al 2001, Garman et al 2002). Collins and Long (2003), state that working with people who have severe psychological problems or mental illness can, over time, have a detrimental impact on the psychological health of mental health workers. They provide a helpful overview of different characteristics and theories in relation to psychological trauma to which professional 'care givers' may find them self exposed. This includes an analysis of what protects workers from experiencing trauma through consistent exposure to their client's own traumatic experiences. Pearlman (1995) suggest that staff who are not

able to psychologically protect themselves from exposure to the adverse effects of their clients experiences can experience depression, cynicism, alienation and an increased sense of vulnerability. Collins and Long (2003) affirm that some caution must be used when considering their findings but create an interesting perspective for the exploration of what contributes to role decline in care givers, balanced with what protects them from this occurring.

Exposure to stressful events in a healthcare setting can have a severe detrimental effect on the wellbeing of staff and can lead to poor experiences for service users and poses a significant challenge to the strategic and operational running of all healthcare providers (Neveu 2008). Earlier studies on the effects of stress on healthcare workers suggested that the problem is exacerbated by a lack of knowledge and awareness regarding stress. Bailey (1985), in his early comprehensive review on the impact of caring, suggested that many healthcare workers were not cognisant of the stressful nature of their role and subsequently. He suggests that workers are not always aware of the psychological demands placed upon them and the individuals' ability to make sense of the stressors ultimately impacts on their ability to cope.

Given the above concerns it is important to consider what is known about stress and how it manifest itself.

2.3 Theories of stress

The definition of stress has, in itself, been a source of much debate, ranging from a purely physiological response, a response to environmental pressures or a reaction to extreme life events. As far back as 1989 Bailey and Clarke identify three approaches to stress;

- 1- An event outside of the person to which they react. The person responds to the external stress by experiencing psychological strain. They suggest this is a model that sees the person as a passive recipient of stress.
- 2- Physiological response to an adverse situation.
- 3- A middle position incorporating both points 1 and 2 outlined above.

They suggest that the individuals own interpretation of the event identifies whether they find it psychologically or physiologically difficult. Their interpretation essentially determines whether or not a stressful reaction will occur.

This analysis of a model of stress, whilst potentially over simplistic, has some merit. It acknowledges the role of each individual in determining what may constitute stress. Whilst this is helpful it does not go far enough in understanding how stress may emerge in the context of adverse life events. Dohrenwend (1998) however suggests three components that are derived from stressful adverse experiences. Firstly he outlines a model of proximal life events, which is how one responds to the full range of possible life events ranging from disaster, death, physical illness and marital separation. Secondly he describes the ongoing social situation, which is the social network for the individual. The context and strength of this network can provide both supportive and detrimental factors to the individual's ability to cope with stress. Finally he outlines the personal predispositions that may act as either protective or exacerbating factors that are likely to expose the individual to extreme or adverse reactions. These include previous life events and how the individual has responded to these, their personal beliefs and values, their psychiatric history and intellect. In the context of this study these components are of interest as these factors may all interrelate through exposure to occupational stress and what enables individuals to cope. This is considered further in section 2.4.

Van-Praag et al's (2004) review of the links between stress and depression develop a theoretical framework that defines stress as a demand on a human being. The individual determines whether the 'stressor' is harmless or represents a threat. This

personal analysis then defines how the individual responds to the stimuli. Van-Praag et al's (2004) acknowledge that the individuals coping ability and personality, heavily influence the determination of a stressful event. However their framework does not readily acknowledge how previous experiences or cumulative exposure to stressors may affect the individual. This gap in the framework seems at odds with earlier studies that recognise that stress may be as a result of insidious exposure to adverse stimuli.

Payne and Horn (1998) earlier analysis placed stress in the context of psychosocial processes in maintaining physical and psychological wellbeing. Their review of the literature provided a theoretical framework for stress that is based upon three specific categories for defining stress (see Table 2.1). They recognise that stress may be either acute or a manifestation of cumulative experiences.

Table 2.1

Payne and Horne (1998) Stress framework

1- Stimulus-based definition of stress; a process where the stressor is an aspect of the environment which places strain on the individual. The environmental exposure can be acute or insidious and, they argue, if not addressed may cause the individual to become unwell.

2- Response-based definition of stress; this is defined as a process where the stress is actually how the body/individual responds rather than an emphasis on the actual trigger or catalyst.

3- Interactional definition of stress; this model is largely a combination of the stimulus and response based definitions. This approach is more widely supported and recognises that stress can be a dynamic process and the reaction and response of the individual may be determined by a number of interacting factors. This element of their model may be more closely associated with the experiences of the participants within this study. Their experiences emerge from a stimulus (the death) and the interacting factors become the response to the process of professional scrutiny.

Other theoretical models of stress include a biomedical model, a biopsychosocial model and adaptation theories (see table 2.2 for overview). All offer slightly varying perspective on the theories of stress but many of the constitutional aspects appear to overlap and are rather broad ranging and all encompassing. I would argue they appear to be largely predetermined by the particular professional or academic background of the authors.

Table 2.2 – Overview of Stress Models

Model	Elements	Authors
Biomedical Model	Theoretical framework for medicine predominately based on physiological disease determination.	Payne & Horne (1988)
Bio-psychosocial Model	Asserts that psychosocial aspects of health and stress are of equal importance to physiological causation. Theoretically identifies equal weight to psychological, social and physiological factors.	Fava & Sonino (2008)
Adaption Model	Theory argues that individual changes (or adaptations) pertain to a stressor. These are delivered broadly, by responses to changes in circumstances and the cumulative effect on the individual.	Hill-Rice (2012)

I am supportive of Radley biographical and cultural model of illness and stress (1993) who suggest that too limited a view on stress prevents real understanding. The focus should be on the individuals own experiences, their understanding and interpretation of their environment, how these factors interrelate and the subsequent response and effect on the individual. I feel this perspective aligns with my need to understand the experiences of the nurses within this study.

The plethora of work on the definition of stress will often propose differing theories or perspectives. Lazarus and Folkman (1984) suggest that researchers should perhaps consider stress as a broad term that facilitates areas for further scrutiny and study rather than a specific homogenous group of characteristics. My analysis of the literature is that that stress sits along a continuum of emotions and behaviours experienced by all. This continuum for stress can vary from positive experience of stress, which leads to enhanced performance and experience of wellbeing, to the more severe end leading to a diagnosis of Post-Traumatic Stress Disorder

2.4 Coping mechanisms and factors that mitigate stress

Inevitably, many of the theories relating to stress make either tacit or explicit reference to coping theories. These are felt to be an essential psychological prerequisite in determining whether the individual perceives the stressor to represent a threat, whether it be immediate or over the longer term. The analysis of this threat ultimately influences the level of stress experienced by the individual and thus their ability to cope (Lazarus 1966).

Lazarus and Folkman (1984) suggest a two dimensional model of coping namely; Problem- Focused coping which takes direct action to solve the problem and Emotion Focused coping that seeks to negate the negative emotional impact of situational stress. From an employment perspective this is a significant determinant in how the individual will experience stress, notably in how the employees are able to influence the removal of the threat or stressor. If the employee is unable to take 'direct' action to remove the threat they then rely more readily on emotion focused coping strategies. The relative strengths and abilities of the employee to positively deal with the psychological stress will inevitably shape their overall response to the stressful event.

Lazarus and Folkman (1984) suggest that the individual uses a three-point appraisal of the situation to determine potential threatening events. This process determines whether the event is

- Irrelevant for the individual or
- Relevant and positive or
- Relevant and negative

They suggest that if the event is both relative and negative this constitutes a stressful occurrence. This approach to understanding coping is helpful but does not sufficiently explain stressful events that may not be acute in their onset.

Further studies expand on early coping theories developed by Lazarus (1966) and identify a schema of behaviours that individuals utilise to deal with stressful events. Carver et al (1989) used a multidimensional coping inventory to assess the ways in which people respond to stress. This study was conducted in three distinct stages, ultimately testing their theoretical model on a cohort of undergraduate students. Peacock et al (1993) further developed this by using a 57 item 'measure of coping' scale on 185 undergraduate students. Both studies identified behaviours that are similar and that seek to either directly address or avoid the stressor. These range from trying to prevent the likelihood of the stressful event occurring or reoccurring, seeking information, avoidance, denial, seeking support and acceptance. These findings are helpful as they recognise both acute and insidious stress and how students endeavour to cope. Importantly they acknowledge the need for a strong support mechanism around the student to enhance the individual's ability to cope. Chapter 3 will further identify that across a range of professional groups this type of coping behaviours are prevalent in avoiding a similar event reoccurring.

2.4.1 Personality factors

The personality of the individual and their ability to deal with stress and significant life events have also been areas of significant study. Van Praag et al (2004), in their comprehensive review of the literature, highlight how the majority of people are able to cope with significant stress and the psychological impact of severe stress through trauma is usually relatively short lasting. However Van Praag et al (2004) recognise variables of personality and the influences these have on the analysis of whether the stimuli represent a perceived threat or not are worth consideration. Much of the research regarding personality has focused on examining behavioural and cognitive

components of the individual's response to stress (Contrada 1989, Edwards 1991). Initially relatively narrow personality theories and constructs were developed in an attempt to gain insight into whether there were predisposing personality factors that meant you were more or less susceptible to stress. These included but were not limited to 'hardiness', 'locus of control' and 'easy going-ness' (Kobasa 1979, Parkes 1984). The development of a personality type A theory by Rosenman et al (1975) outlined a series of characteristics that were more likely to predetermine exposure to stress with an adverse physical reaction. These characteristics included competitiveness, hard driving, job involved and hostile. This theory is helpful but potentially limiting in that it infers that within the Type A theory both personality and behaviours are intractable and not amenable to influence or change. Danna and Griffin offer a counter view (1999) suggesting that this does not readily capture all the complexities of personality factors and particularly how the individual can be supported to interact more appropriately with their fellow employees.

In contrast to these particular theories an attempt to develop a more unified approach to understanding personality was developed under the auspices of the five-factor model (John 1990, McCrae and John 1992). The five factors or domains are

- Neuroticism
- Extraversion
- Openness to experience (or culture)
- Agreeableness
- Conscientiousness

Within each of the five domains are a number of 'traits' that broadly correspond to previous research on personality factors, particularly research on neuroticism, extraversion and conscientiousness. The advantage with this model is they are all drawn together as part of one theoretical framework.

It remains that the five-factor model is frequently cited as the most effective and robust way of drawing together the various theories on personality factors that may predetermine ones susceptibility to stress. However Vollrath (2001) cautions that no one series of traits or characteristics can be considered in isolation from all the other variables that exist for the person, notably that many of these traits are inextricably entwined with ones coping strategies.

2.5 Trauma

Figley (1985) defines trauma as events that are dangerous, overwhelming and sudden. These events are determined by extreme or sudden force which typically cause fear, anxiety, withdrawal and avoidance. They are often of high intensity, unexpected, infrequent and vary in duration from acute to chronic. This view is potentially limiting in that the focus is on the cause of the psychological response rather than the response itself. A broad-brush approach that suggests it is an event that sits outside of the range of 'usual' human experiences seems ill-defined and inadequate.

Davidson and Foa (1991) address this in their consideration of diagnostic criteria for PTSD. They acknowledge the actual response of the individual is a more important denominator than the actual event itself. Adshead and Ferris (2007) meta-analysis concur that the response of individuals is paramount and note that some individuals will be left untouched by events that others may experience as psychologically traumatic with life long consequences.

The psychiatric diagnostic classifications of trauma are largely determined by the range and type of apparent behaviours and psychological responses. Potential diagnoses for trauma related events range from, at the most severe end, PTSD to others such as 'adjustment disorders, anxiety, depression, dissociative disorders and enduring personality changes after catastrophic experience.

The precursor to most literature on trauma and psychological stress in its extreme form has been the impact of warfare. Theories of stress and trauma gained more widespread recognition following the First World War with the advent of the term ‘shellshock’. This term was derived after the behavioural and psychological characteristics developed by soldiers was believed to be due to the close proximity to loud explosions. The onset of the Second World War began to see greater attention paid to the psychological stressors of warfare on soldiers. Early studies by Grinker and Spiegel (1945) and Kardiner (1947) started to describe some of the symptomology in soldiers that is now more commonly associated with a diagnosis of PTSD. However it is arguable that the psychological harm of warfare did not receive widespread and sustained international attention until the war in Vietnam. Keans’ (1998) literature review provides a description of how the gradual national recognition by the United States of America regarding the debilitating effects of war on their soldiers, was the precursor to large-scale studies on stress and trauma.

The Vietnam War was thought to be the catalyst to the development and importantly the formal recognition of a cluster of severe behavioural and psychological traits that developed following exposure to a traumatic event. This was ultimately classified as the formal psychiatric diagnosis of Post Traumatic Stress Disorder (APA 1980). Bennets’ (2006) review of psychological disorders suggests that PTSD sits at the severe end of a range of pathological psychological reactions to stress and is characterised by the following characteristics:

‘Where the individual has experienced or witnessed an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others, and that their immediate response involved intense fear, helplessness or horror. In the longer term the individual must have experienced three clusters of symptoms lasting one month or more;

- *Intrusive memories*
- *Avoidance*
- *Arousal’*

Studies have identified that the prevalence of Post Traumatic Stress Disorder in the armed forces ranges from 15% to 53% (O'Brian and Hughes 1991 and Schlenger et al 1992). The prevalence of PTSD has also been subject to a number of studies across the whole community rather than specific to a single professional group. Kessler et al (1995) indicates a lifetime prevalence for PTSD in 7.8% (women 10.4%, men 5.0%) whilst others suggest a range of 1.5% to 3.4% (Stein et al 1997, Andrews et al 1999).

In an attempt to clarify what is known regarding PTSD the National Institute for Clinical Excellence published practice guidance on PTSD (2005). Within the guidance it outlines people at risk of PTSD, which include (page 7);

'People exposed to extreme traumatic stressors such as deliberate acts of violence, physical and sexual abuse, accidents, disaster or military action. This includes both direct personal experience of the trauma and the threat to the physical integrity of the individual involved.'

The guidance also suggests that particular occupational groups will experience an increased likelihood of exposure to PTSD including police, military service, emergency personnel and journalists. The guidance concurs with other schools of thought on trauma and affirms that, for those who experience the death of someone close, they may also be susceptible to a traumatic reaction. This final point from NICE is significant. Chapter 3 considers how the nature of the relationship between the worker and the deceased may play an important part in determining the psychological response of the individual.

2.5.1. Secondary trauma and second victims

Earlier studies on PTSD suggest how the trauma needs to be extreme and personally experienced by the individual. NICE (2005) broaden this definition slightly but others would suggest the experience of secondary traumatic exposure, second victim phenomena or vicarious traumatisation for health care workers is more likely in the context of psychological stressors experienced through employment (Wu and Steckelberg 2012). This is important as it recognises that employees may experience adverse psychological effects akin to PTSD. Jenkins and Baird's (2002), study of 104 trauma counsellors using a range of quantitative inventories to ascertain exposure to psychological stress is a useful example. They found employees are traumatised through exposure to the direct and indirect experiences of the clients they work with. This form of trauma has been variously described as secondary traumatic stress, vicarious traumatisation, burnout and compassion fatigue. These are broadly differentiated by the onset of the psychological effects and the types and intensity of the experiences. Burnout is more frequently associated with prolonged exposure to psychological stressors. Secondary trauma refers to emotional and psychological reactions to the experiences of the clients they are working with. However the symptoms experienced in secondary trauma are similar to PTSD but with less intensity and characterised by intrusive thoughts, anxiety and depersonalisation. These types of studies are helpful in developing our understanding of how employees respond to the cumulative effects of working with distressing circumstances. However they offer less insight into how staff respond to an acute situation such as a suicide or unexpected death.

A further development in the understanding how occupational stressors in healthcare may lead to psychological distress was the identification of what is described as 'Second Victims'. Wu's (2000), analysis of the experiences of staff involved in patient safety incidents found that the resultant psychological consequences go largely unrecognised. He suggested that staff could experience severe emotional and

psychological distress following an adverse clinical event. Wu (2000) subsequently developed the concept of second victim when considering the effects an adverse event or patient safety incident has on clinical staff. Scott et al's (2009) qualitative study undertook interviews with 31 'second victims' using semi-structured interviews. From this study they defined second victims as '*a health care provider involved in an unanticipated adverse patient event, medical error and /or a patient related injury who become victimised in the sense that the provider is traumatised by the event*'. Whilst this definition was helpful much of the literature deals with the experiences of staff after an error has occurred (Rassin et al 2005, Scott et al 2008, Edrees et al 2011, Wu and Steckelberg 2012). This issue of error recognition is important, as often within mental health services suicides and unexpected deaths cannot be routinely attributed to a direct 'error' on the part of staff.

The issue of error occurrence is also relevant in determining prevalence of second victim phenomena. Studies vary from 10.4% to 43% but differ in relation to effects of witnessing an error to the actual impact of making an error (Wolf et al 2000, Lander et al 2006). Scott's (2011) survey of 1160 hospital staff suggests that one in seven members of staff will experience a patient safety event that causes them psychological distress.

Ultimately all the studies identify the psychological consequences for some staff that may arise from an adverse event. These include acute stress disorders, depression, feelings of guilt, anxiety, shame and symptoms reminiscent of PTSD. These symptoms include intrusive recurrent thoughts about the incident, nightmares, fear of repetition and avoidance of similar clinical situations. Staff also report feeling responsible for the incident and describe how they feel they have failed (Denham 2007). So profound are these experiences that they can overspill into the individuals' personal lives and can have a detrimental effect on home and family life. Aasland and Forde (2005) conducted a questionnaire based study on 1616 doctors looking at their response to adverse events. They identified that one of the main consequences

of the incident was the impact on their personal lives and the difficulty in ‘switching off’ the intrusive thoughts and feelings. Psychological distress was compounded when the individual felt blamed by the organisation and distress was heightened by a fear of disciplinary action or potential loss of professional registration (Scott et al 2009). These feelings were prolonged in the more severe events by the process of investigation and scrutiny by their respective organisations (Raissin et al 2005). Further factors that exacerbated the psychological response include the actual severity of the incident, the emotional connectivity between the member of staff and the patient and a negative response from peers. This tells us that following an error; clinical staff may experience significant psychological distress. This distress can be heightened when the individuals are subject to scrutiny and/or feel blamed by their employer. What I cannot locate are studies that have been undertaken specifically in mental health settings. Therefore, whilst the psychological responses of staff are of interest, the clinical circumstances are different to my study.

Second victim studies affirm the importance of offering support for staff involved in patient safety incidents. Scott et al’s (2008) identifies the need to offer timely post incident support for staff and for managers to reinforce that they have ongoing confidence in the individual. Wolf et al’s (2000) descriptive correlational study of 402 healthcare staff identifies the importance of fellow colleagues, friends and family as a critical factor in preventing the individual experiencing an adverse psychological response to the event. Edrees et al’s (2011) survey of 350 clinical staff extended the study by Wolf et al’s (2000) and specified that effective support is best delivered by clinically credible staff who work in a similar environment. Sirriyeh et al’s (2010) undertook a systematic review of research evidence that considered the effects of medical errors on the psychological wellbeing of professionals. This resulted in a review of 24 papers that met the inclusion criteria pertaining to second victims. The study concurred with other evidence in relation to the psychological effects of second victim phenomena. However, in terms of support systems, they also noted that whilst peer support for victims was important it was regularly lacking. Wu

and Steckelberg (2012) argue that health providers must offer more robust support for staff including training that identifies the likely responses of individual to errors. The notion of the type of support is interesting and relevant to understand what support, if any, may have been offered to the participants in this study.

2.6 Conclusion

This chapter affirms that occupational stress can have a profound effect on the employee. The population within the studies varied and included students, soldiers and healthcare workers. However at its extreme it can result in staff unable to work or providing sub optimal care. This chapter has identified some of the theories that underpin stress and present a basis for discussion regarding what may ameliorate or aggravate the likelihood of psychological stress occurring. It is widely accepted that stress forms part of a continuum of psychological responses that, at their most severe, can have profound effect on the psychological wellbeing of the individual. This can be evidenced through literature on PTSD, secondary trauma and second victim phenomena. The literature on second victims is of particular interest to this study given the experiences of staff following an adverse clinical event. It is also of interest that I was unable to locate any studies on second victims that pertain solely to mental health services and mental health personnel.

The second victim studies have identified that psychological distress may be evident if staff feel they have committed an error. They do not address how staff may react in the absence of an error occurring. Existing literature on secondary and vicarious trauma establish the psychological distress attributed to insidious effects of working in stressful situations. However they make little recognition to the potential ‘acute’ reactions of staff from situations such as suicide. Both of these specific omissions in the literature are areas of interest for this study.

Dohrenwend (1998) suggests most people have some element of control over their exposure to psychological stress. There is then perhaps a distinction between exposure to psychological stress as part of 'routine' life events and those who experience stress or trauma as a result of their occupation. This study is interested in the experiences of staff after an unexpected death or suicide and the subsequent process of professional scrutiny. Chapter 3 will explore what is known about the effects on staff following an unexpected fatal incident and subsequent process of professional scrutiny.

CHAPTER 3

UNEXPECTED DEATHS AND PROFESSIONAL SCRUTINY

- A REVIEW OF THE LITERATURE

3.1 Introduction

Chapter 3 focuses on the literature that establishes what is known about the experience of working with an unexpected death and suicides and the subsequent process of scrutiny. The chapter is integral to this study as it draws upon the wider body of research that provides insight into the experience of non-nursing professions including police officers, social workers, emergency workers and military personnel. This review identifies the impact of the process of scrutiny and the psychological consequences for staff. The sources of literature available are, by their nature, rather disparate. Therefore an integrative approach is adopted to identify the themes that emerge from a diverse range of studies. To assist the reader the chapter is written utilising the main areas that the literature reveals. The chapter will firstly consider what the nursing literature identifies and then establish what themes emerge from other literature. These themes are;

- The psychological effects on staff
- The relationship with the deceased
- The inquiry or investigatory process
- Blame and accountability
- The response from the employer
- Previous experience

The chapter concludes by presenting a visual representation of the common themes that emerge from the diverse literature.

3.2 The Nursing Literature

Before commencing the analysis of the wider literature it is worth considering what is known specifically in relation to mental health nursing. Farringtons' (1995) early literature review on suicide and the importance of offering support for staff affirmed how further research was vital. Farrington considered studies that pertained to suicide and psychological debriefing. He argued that the literature at that time did not address the psychological consequences for nurses after a suicide. Midence et al's (1996) survey of 27 nurses identifies some adverse emotional responses to suicide. The questionnaire used was developed based upon previous tools designed to assess coping skills. The study is limited to inpatient nurses and, whilst helpful, does not reflect how mental health services are now primarily delivered in the community.

Gilje et al (2005), in a secondary analysis of interviews with 19 nurses whose patients had committed suicide, established that more studies are required to understand how nurses react to a patient's death and cope with the psychological consequences. Through the use of thematic analysis they identified that the 'despair' and 'distress' that was evident required more research. Cutliffe et al's (2006) grounded theory study explored the effects on nurses of working with suicidal patients. Twenty service users thought to be at high risk of suicide participated in the study. The authors make recommendations for preventing suicide and understanding the experiences of nurses who work with this high risk group. Importantly they outline the paucity of work that pertains to nurses on the effects of successful suicides.

Research to date has also focused upon the care of suicidal clients with little emphasis on the experience of the nurse following the client's death. (Maude and Beverly 1992, McLaughlin 1999, Anderson 2000, Joyce and Wallbridge 2003, Sun et al 2005, Cutliffe et al 2006, Sun 2006, Carlen and Bengtsson 2007 Aflague & Ferszt 2010). Representative of these is the study by Botega et al's (2005). Using the

Suicide Behaviour Attitude Questionnaire 317 nurses responded, 87% felt unprepared when working with suicidal patients. The study illustrated some of the anxieties nurses face when working with this client group but does not address the actual experience of the effects of a suicide.

Long and Reid (1996), Valente and Saunders (2002) and Valente (2003) provide greater detail on the specific impact on nurses. Their work acknowledges that the effects on mental health nurses generally mirrors that of other mental health colleagues but they outline that further research is required to address the specific elements that may be unique to nursing. Valente and Saunders (2002) undertook a Meta analysis on the impact of suicide on nursing staff. They considered all published literature from 1965 to 2001. They identified the emotional impact on nurses and liken it to a bereavement process seen in other professionals. However they further suggest that nurses often have a different type of relationship with their clients and this requires further study. They suggest that the effects on nurses are in part determined by the nature of their relationship. What these studies do not tell us is whether the nurse was subject to investigation or professional scrutiny. In the context of modern health care and the culture of accountability this is an area for further exploration.

One of the themes that emerges from the literature is changes to clinical practice. Hardy and Mingellas (1997) review of suicidal behaviours, discuss how some people irrespective of all the efforts of those around them will still choose death. Survivors, including professional staff, are left with a range of feelings including shock and disbelief. This is of particular interest when considering the increasing pressures placed on staff in relation to risk management. There is a tacit acknowledgement that even when everything is done to negate the likelihood of suicide occurring, some people will still succeed in taking their own life.

The most common changes in practice include; clinical cautiousness; an over-vigilance towards risk assessment and risk management; and a hesitancy in making, what were previously, routine decisions. Valente (2003), literature review on nurse's reactions to suicide, indicates that following a patient suicide some staff will avoid working with other patients who may proffer a similar risk. More specifically some will become so risk adverse that they will no longer wish to work with clients who may represent a risk of suicide. This avoidance of situations is a phenomena that is common to other groups of staff working across a variety of agencies and services. What the literature review does not reveal is how long staff take this evasive actions and what ameliorates recovery.

3.2.1. Summary of nursing literature

The absence of literature on mental health nurses is perhaps surprising given the increasing emphasis on professional accountability. Equally there is little recognition of the experience of mental health nurses in the aftermath of the death and the subsequent process of scrutiny that inevitably follows. In the absence of these studies the chapter will now consider the wider literature. Specifically this will include other professional groups and or industries that provide greater understanding of the human experience of an unexpected death and the associated process of inquiry.

3.3 Psychological effects on employees

The literature on second victims discussed in chapter 2 outlines a range of adverse psychological response that result from a broad range of patient safety incidents in healthcare. The impact on staff when working with fatal incidents spans various professional groups. In certain occupations, by the nature of their role, one may

expect to see an increased likelihood of experiencing exposure to serious events that lead to death.

Outside of healthcare this includes police firearm incidents when innocent bystanders are involved or when the use of 'deadly force' may have been considered unnecessary. Gersons (1989) showed that for some police services firearm incidents are a relatively rare phenomenon, however, when incidents occur, the impact on officers may be severe. Hodgins et al's (2001), longitudinal repeated measure study of 367 police officers found that the likelihood of experiencing psychological trauma was influenced by the nature of the incidents themselves. Specifically whether stress was evident from the cumulative effect of multiple exposures to stressful events or whether they were exposed to a 'big bang' event that was severe for their 'normal' range of experiences. Measures included symptom measures for PTSD, risk factors measures (designed to assess personality traits in response to stressful events) and trauma measures, to ascertain level of exposure to traumatic events experienced during service. One of the intriguing findings from this study was the prior exposure to 'sad incidents' has an 'inoculating effect, meaning that this may provide some protection to severe traumatic reactions.

Hodgins (2001) offers a contrary view that prior experience of similar events is insufficient to explain the development of traumatic reaction. Renck et al (2002), however, suggest that police officers routinely exposed to stressful events develop 'immunity'. This may be because the greater number of difficult situations faced the more likely the police officers are to forget previous traumatic events. This is different to other studies, notably Stephens and Miller (1998), who found that the greater the number of different traumatic events experienced by police officers, the more likely symptoms of PTSD would be present.

Stratton et al (1984) reviewed sixty deputy sheriffs involved in shooting incidents in Los Angeles using a seven-page survey delineating their reaction to the shootings. A

considerable variability of positive and negative emotional reactions was found, with 30.5% identifying that they were experiencing significant trauma following the incident. The symptoms included poor sleep, disturbance in sleep, intrusive thoughts, nightmares, flashbacks, hyper-vigilance and avoidance of risky situation that may replicate their earlier experience. These police studies are interesting as they offer different views on the time onset of the trauma, namely if the effects are cumulative or acute. They also suggest that prior exposure to incidents may provide a protective component for staff. This area has not been previously explored with mental health nurses.

Gustavsson and MacEachron's (2002 page 911) model (see Table 3.1) assesses the likely impact of child death on the worker. They suggest that the effects on the practitioner are more pronounced if the death is traumatic and when they had strong personal feelings towards the child. This study is relevant as the criteria are similar to the circumstances that nurses may find themselves. What the study does not clarify is what constitutes 'strong feelings'. This is important as nursing studies state that nurses may also respond differently to deaths due to the nature of the relationship. I feel these perspectives are too broad and require further scrutiny.

Table 3.1

Relationship with client	Type of client death	
	Sudden	Anticipated
Negative	Initial shock Transitory sadness	Little/no shock Existential evaluation of life/death
Positive	Initial pain Limited grieving PTSD risk	Painful loss Extended grieving Complicated grief risk

Studies of personnel who have experienced a death in custody have indicated prisoner suicide is a significant contributory factor to prison officers experiencing severe stress reactions similar to Post Traumatic Stress disorder (Rogers et al 2003). Wright et al (2006) undertook a study on 49 prison officers that considered the impact of self-inflicted deaths in custody. They used a cross sectional design and self-report questionnaire with data being administered through semi-structured interviews. They found an incident rate of 36.7% of prison officers displaying symptoms of PTSD following this traumatic event. They also identify how the prevalence may be even higher than found, pointing to exclusion criteria that ensured prison officers with pre-existing 'clinical symptoms' were not studied.

They identify a four-factor model that identifies a person's vulnerability or resilience to coping with extreme and adverse situations. They identify areas that they feel may influence the potential impact on the member of staff (see Table 3.2)

Table 3.2

Four-factor vulnerability model
<ul style="list-style-type: none"> • Locus of control, (How much an individual can control their situational and/or environment) • Problem solving style (How the individual is able to develop effective coping strategies) • Optimism / Pessimism (The impact of extreme optimism and pessimism on the reality of the role/situation) • Perceived social support. (High social support networks that can moderate the effects of adverse events.

The significance of coping strategies is also found within workers who are dealing with traumatic events. Clohessy and Ehlers (1999) undertook a study of 56 ambulance personnel using a questionnaire to determine levels of work related stress and evidence of PTSD. They identified the psychological responses of emergency workers did not amount to a formal diagnosis of PTSD but adopted a series of 'coping strategies' to manage the stress of the frequent exposure to critical events. These included such behaviours as avoidance, distancing and 'educational desensitisation' that is '*workers reinterpreting gruesome scenes as specific protocols to go through*'. They detail some of the experiences that participants identify as causing the most intrusive and distressing memories, the most severe being those that involved death. The impact of death through suicide, and the effect on the mental health of personnel was noted as an area of significance, particularly where the ambulance worker knew the victim. They found that a substantial proportion of workers (21%) report levels of trauma and symptoms associated with PTSD, a further 22% demonstrating some evidence of symptoms associated with a psychiatric disorder. This study provides an insight into some of the psychological effects experiences by exposure to traumatic deaths. It is relevant as they identify suicide as an area that has particular profound impact on workers.

The literature on the effects of suicide on psychiatrists represents the most extensive category in mental health services (Gitlin 2006). The studies generally emphasise the likelihood of psychiatrists experiencing a patient death through suicide. Dewar et al (2000) suggest that all psychiatrists may experience at least one suicide during the course of their career. Questionnaire surveys predominate with the use of Likert rating scales allowing some space for free text comments. Some used standardised rating scales (Domino et al 1982, Chemtob et al 1988, Diekstra 1993, Rogers et al 1995). Most were undertaken as postal surveys with sample sizes ranging from 586 (Chemtob et al 1988) to 89 (Yousaf et al 2002). Various studies outline the detrimental effects of suicide on psychiatrists (Chemtob et al 1988, Kaye and Soreff 1991, Pompili et al 2002, Ruskin et al 2004). Relatively early studies (Litman 1965,

Jones 1987, Ruben 1990) outline how the effects on staff can be broadly divided into two categories, namely, personal and professional. The majority of studies focus on the emotional effects on psychiatrists which commonly include feelings: shock; anger; guilt; denial; depersonalisation; humiliation and symptoms of post traumatic stress disorder.

Chemtob et al (1989) identify that suicide is also an important occupational hazard for psychotherapists and argues that working with suicidal patients is the most stressful aspect of their work. Tillman's (2006) phenomenological study of 12 therapists argues that insufficient regard has been paid to the impact of the patient's death on clinicians. Much of the literature that considers the effects of suicide on therapists reflects the particular therapeutic modality of their professional training. Studies often emphasise the impact of the death on the therapist utilising a particular analytical approach (Jones 1987, Berman 1995, Kind 1999, Hendin et al, 2000). Their therapeutic training and style heavily influence their interpretation of the impact of the death. Whilst this informs the particular therapist using that treatment modality it limits the extension of learning across disciplines. Nurses are often employed to work across a range of services. Therefore it is difficult to discern what may or may not readily apply to the nursing profession.

Tillman (2006) supports the work of Gabbard (2003) in suggesting much of the claimed personal impact on the therapist when faced with client suicide merely reflects a 'normal' process for grieving. However both Gabbard (2003) and Tillman (2006) outline the specific professional consequence for the therapist. This includes self-recrimination, becoming risk averse and developing a reluctance to work with clients who may be suicidal. Saunders and Valente (1994) suggest that much of this is compounded by the individual's self doubt regarding their professional role competence and a fear that colleagues will blame them for the death of the patient.

McGinley and Rimmer (1994) outline the impact of suicide on all staff groups irrespective of professional background or training. They identify a sense of confusion arising from caring for the deceased and suggest that staff are left feeling resentful, angry or ambivalent. This is common amongst a number of studies. Illustrative of this is Linke et al (2002) who examined the effects of suicide across 44 staff in multi disciplinary community mental health teams. Using a questionnaire with free text they identified that 40% of staff reported adverse effects on their personal and professional lives that lasted over one month. These findings reflect some of the effects on staff that emerge from the studies. They do not consider whether a process of professional scrutiny extends the adverse experiences of staff.

3.4 Relationship with the deceased

Mental health nurses provide the majority of the care in statutory mental health services; particularly in-patient settings and they frequently make up the majority of the workforce within the NHS (DOH 2006). Moreover, they are more likely to be working with those people who are in crisis or reluctant to engage with services, arguably those who are most at risk of self-harm. Irrespective of suicide being a rare event, little has been published regarding the specific impact of caring for suicidal patients on nursing staff (Valente and Saunders 2002, Collins 2003, Gilje et al 2005). This omission is particularly interesting as studies of other occupations highlight how important the relation with the deceased can be when determining the likely response from the employee. It is appropriate then to consider what other professions have identified regarding relationships with the deceased.

Gustavsson and MacEachron's (2002) thematic review on the effects of child deaths for their social workers is revealing. They identify that dealing with death is compounded for childcare workers as it remains a relatively uncommon experience. The impact is heightened, as the practitioners are more likely to be familiar with supporting families of those grieving, rather than coping with their own grief issues. This feeling of not knowing how to cope is heightened where there has been a strong

relationship with the client and exacerbated further if the death is sudden, unexpected and traumatic. This study is noteworthy as the circumstances social workers find themselves in may be similar to that of nurses.

Green (1985) in a review of emergency workers identified that one of the most distressing factors for staff was working with the death of someone they know. Green (1985) suggests that the relationship with the victim was a significant determinant in how staff cope with the situation and reconcile any ongoing emotions about their involvement in the event. Regehr (2003) mixed methods study of 37 emergency workers identifies how one of the most distressing factors was the participant knowing the deceased. A further distressing element was a suicide.

Ursano et al's (1999) study of 54 disaster workers identified that the likelihood of increased severe stress response was heightened if they knew or were friends with the deceased. This quantitative study used a variety of trauma rating scales repeated at differing time points. It identified any emotional resonance or connectivity with the deceased indicates the likelihood of increasing the psychological stress experienced by the worker. Cetlin et al's (2005) affirmed this view identifying that the effects on the worker were more profound if they were able to identify with the victim. The adverse effects on emergency personnel were also heightened if they knew the deceased, an interesting analogy for mental health nurses who work closely with their clients.

The evidence suggests that the nature of the relationship may be an important denominator in how the individual responds to the death. This appears particularly important if the death is through a suicide. This insight is helpful. What the studies do not clarify is whether the death is magnified because of an emotional response to the nature of the death, or in response to witnessing the body. Neither do the studies indicate if it may be a combination of both these aspects. This point is important as

some nurses will experience deaths in inpatient setting and may be required to resuscitate the patient.

3.5 The inquiry and investigatory process

After a serious untoward incident such as suicide or an unexpected death, an internal investigation is commissioned in line with NHS guidance (NPSA 2008). This investigation should consider all matters that led up to and possibly contributed to the incident. In undertaking this process, NHS Trusts will be cognisant that in cases of suicide both the investigation report and staff involved may be required to attend the coroners hearing. It is noteworthy therefore that the few studies on mental health nurses and unexpected death and suicide pay scant regard to the impact of investigation and or coronial proceedings. This is an interesting omission given the requirements for these investigations to take place. A small number of studies within mental health settings make brief reference to the adverse effect of legal proceedings and specifically the inquests that follow a suicide (Hodelet and Hughson 2001, Campbell and Fahy 2002, Pompili et al 2002). They suggest that the proceedings further compound the feelings of distress experienced by the practitioner.

The investigatory process is found within most areas of the public sector particularly in public services which involve contact in difficult situations or when enforcing legislation. These investigations may be the precursor to internal proceeding or if a death is involved scrutiny from a coroner. The effects of professional scrutiny go well beyond health care. For example it is generally accepted that police officers undertake a difficult and challenging role that will, at times, expose them to situations which are extremely stressful and outside of the general range of experiences seen by other members of society (Hart et al 1995, Carlier et al 2000, Hodgins et al 2001). The primary function of the police service is brought to a sharp focus when police officers may be accused of transgressing internal organisational policies or indeed breaking the law themselves. The level of scrutiny associated with

the review process can be a source of enormous personal distress. Bale (1990), in a review of USA case law, outlines how severe the impact is on police officers when they are accused of committing an offence, particularly when the offence may be seen as part of undertaking their normal duties.

Regehr et al's (2003), qualitative analysis of the experiences of eleven police officers who had participated in public inquiries. The study examined reactions to the events that led to the inquiry, the review process itself, the impact of both internal and external communications and media attention and finally the support and response from the officer's employers. Interviews used a semi structured interview guide to ensure officers outlined their experiences about the events. The study utilised the framework for assessing the reliability of qualitative data as developed by Erlandson, Harris, Skipper and Allen (1993). The credibility of the study was enhanced through the collection of some limited quantitative data, which, when triangulated with the qualitative data, was then compared to previous studies on fire fighters and paramedics who had been exposed to post mortem inquiries. The small amount of quantitative data was thought to be too small to be statistically analysed so a descriptive comparison was utilised. Two sets of measures were selected to evaluate social support and current level of distress respectively. In relation to social support the Social Provisions Scale was applied to participants. To determine levels of distress, two separate scales were utilised, namely the Beck Depression Inventory and the Impact of Event Scale.

The study identified that the impact of inquiries on the police officers led to a number of negative effects including;

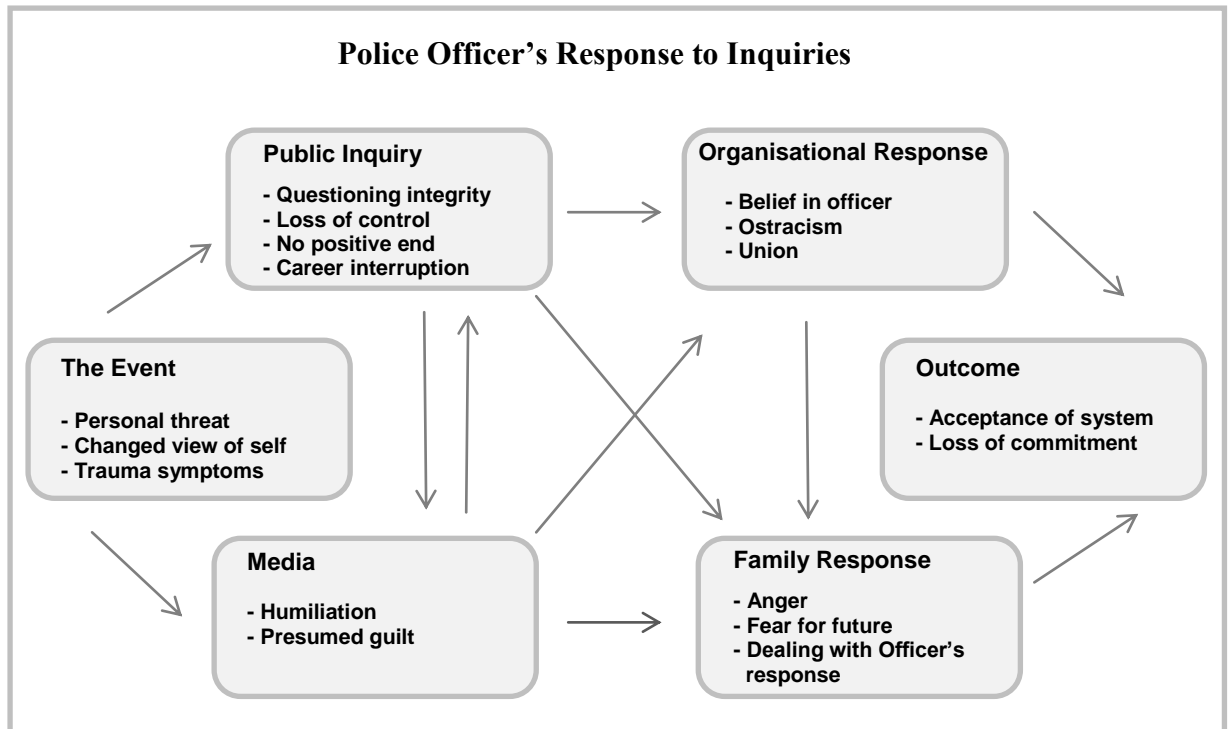
- The emotional impact of being scrutinised (Subjects outlined a variety of emotional responses to the inquiry including anger, depression and anxiety)
- Delays in career advancement resulting from prolonged investigations (Participants highlighted that they felt the process of the inquiry raised doubt about their professionalism and potentially impeded their career)

- Humiliation within the organisation and the wider community (Participants outlined how a prolonged inquiry process made them feel that the wider organisation was embarrassed by their practice. This was further compounded when they faced scrutiny from the media)

Despite the negative impact of inquiries it was further identified that some features mitigate the effects of the inquiry process notably the support of senior officers, who have an understanding of the demands placed on police officers, grounded in their own personal experiences. Some studies on the impact on psychological trauma on police officers have identified that it is not the incidents themselves that are most traumatic for the police officers but the response of their employers (Rallings 2000, Stephens 1996a). It has been further noted that robust social support networks also mitigate against the severity of the trauma experienced (Stephens 1996b,). This study is particularly relevant to my research. Regehr et al's (2003) give a detailed analysis of the adverse effects of scrutiny on police officers. What the study does not address is whether this scrutiny would feel worse if there was a emotional connectivity with the deceased; specifically would the combination of being close to the deceased and then having to account for your action make the experience worse.

Regehr et al (2003) developed a thematic model (Figure 3.1) of police officer's response to inquiries which seeks to explain the potential experiences of the officers and indicate suggested opportunities for intervention to negate the negative impact of the inquiry process. Regehr et al's model is beneficial to this study as it provides helpful insight into some of the experiences that follow an untoward event and the subsequent inquiry. The model constructs some of the experiences of police officers although the nature of their work may be, on 'face value', very different to nurses. However the personal experiences of the officers may provide insight into the human experience of death and scrutiny.

Figure 3.1



In a more detailed analysis of her qualitative data derived from semi-structured interviews, Regehr (2003) found that the impact of the incident affected both the organisation and the individuals involved. This study was conducted with members of four emergency service organisations, including police services, ambulance and fire services. Thirty-seven members of staff were interviewed; all of who had been through a coroner's inquiry following the death of a subject they had worked with. These subjects include those that had died through shooting incidents, deaths of prisoners in custody and deaths of patients on their way to hospital. Interviews followed a semi-structured interview guide. The study found that the individual worker often felt unprotected, attacked and were presumed guilty. These feelings were magnified by a perception that their respective organisations were trying to distance themselves from the actions of the individual and avoid public liability whilst been seen to hold someone to account. Participants were particularly critical of the lack of management support when undergoing the inquiry process, not only for themselves, but generally failing to recognise the detrimental impact the process was

having on their immediate families and loved ones. Whilst this study identified a number of negative experiences some positive aspects were evident. These included organisational learning and system change. An important aspect for the individuals was recognition that their actions, irrespective of the outcome to the deceased, were not at fault. This was stated as one of the most important factors in determining how they were able to reconcile the whole experience. Most participants believed the inquiry process was, in itself, a reasonable expectation for workers to demonstrate how their roles are accountable to the public. However where participants felt that they had not been exonerated they were left with high levels of anger and animosity towards their employers with heightened feelings that somehow they had been used as an organisational scapegoat.

In a further study by Regehr et al (2003) the authors identify that following major disasters, such as the terrorist incident on September 11th 2001, after an initial period of support from the public, emergency services can face intense scrutiny to see if more should have been done to save lives. This 'scrutiny' is often under the auspices of public inquiries or coroners courts. Regehr et al's (2003) identify that for those personnel subjected to this level of inquiry it can lead to significant levels of traumatic stress that are not found in colleagues who are not required to give evidence to such hearings. Furthermore they identified that for those involved their attendance at the hearings can be more traumatic than the actual incident itself.

In social care this process of review is similar in its investigatory duties to other public bodies. Regehr et al (2002) undertook a mixed method study designed to understand stress and trauma in child welfare workers, with the inclusion of staff that had been involved in an inquiry process. A survey was issued to all relevant childcare workers and a response of 33% (n175) was returned. Participants identified that 22% (n 38) had been involved in a formal review of a child death. A key finding was that thirty two of the respondents had their actions questioned as part of the review process with fifteen of these feeling that they had been specifically criticised.

The study identified that participants found inquiries following a death as '*horrendously stressful events*'. This relates to a number of factors including the personal effect of the death on the individual worker, followed by the process of organisational scrutiny which for some, is heightened further by attending a coroner's hearings. Interestingly the study also acknowledges the effects of the inquiry process on the individual organisation and on those working alongside the individual. Within their analysis Regehr et al (2002) identify a number of factors that contribute to the distress (Table 3.3). Axford and Bullock (2005), in a comprehensive review of research literature on child deaths, stated that those involved in a child death review process identified the need for a number of clear determinants that would make the process more beneficial for all involved. These included having clear terms of reference for reviews, clarity on how difficult issues may be addressed as they arise, and a clear process on how other agencies may be involved in the review. It was felt that clear communication strategies with family members were important.

The effects of inquiries can be extended to other areas of the public sector. It is particularly interesting when one considers areas where fatal outcomes are seen to be inevitable. The role of the armed forces is increasingly under public scrutiny with the onset of greater telecommunications and the subsequent glare of the media. Kilshaw (2004), in a study of Gulf war syndrome, outlines how more military personnel died in friendly fire incidents than were killed by enemy fire.

The personal consequences for the 'perpetrators' of these unexpected events are of relevance to this study. Hewitt (1992), reports on the case of Lieutenant Colonel Ralph Hayles who whilst the pilot of an AH-64 Apache helicopter, destroyed a US Army light infantry vehicle believing it to be an enemy vehicle. The result of the attack left two American service men dead and a further six seriously injured. Hewitt (1992), reports that Hayles was overcome with grief and took immediate

Table 3.3

Contributory Factors to Personal Distress

Personal Distress

- The trauma of a child death (Participants outlined the death of a child was the most emotionally distressing professional event)
- Re- exposure to traumatic stimuli (How the inquiry process requires them to re-examine the event in minute detail)
- All consuming nature of inquiries (How the process of the inquiry can seem to subsume all aspects of the individuals life both personally and professionally)
- Criticism of personal and professional integrity (How the inquiry process can feel deeply critical)
- Isolation (Participants outlined how they felt a sense of isolation or disconnect from the organisation)

Radiated Distress

- Empathy for colleagues undergoing review (How colleagues of the individual professional involved felt a sense of understanding and sympathy)
- Scrutiny of agency (How the wider organisation also felt exposed to scrutiny)
- Guilt by association (The wider organisation feeling that they were also culpable)
- Restrictive guidelines for practice (The development of policies that were often as a knee jerk reaction to the adverse event)

Weakened Public Support

- Negative and extensive press coverage (The extent of the press coverage on the morale of the organisational and the individual)
- Hostile public reactions (The response of the public when it is perceived that the child death is a result of individual or organisational failings)
- Tainting of the agency and its workers (The adverse effect of the reputation of the organisation and the individual members of staff)

responsibility for his actions. Hayles was subject to internal disciplinary proceedings and was subsequently removed of his command and ultimately left the army. Shrader (1992) suggests that in the overall context of warfare disciplinary procedures are relatively rare. Both Schrader (1992) and Hewitt (1992) postulate that the outcome of the disciplinary was almost certainly influenced by the political situation at the time. Politicians were becoming increasingly sensitive to public outcry regarding friendly fire incidents and potentially were looking to overtly hold people to account for perceived failings.

The notion of being seen to punish or blame personnel through the auspices of the investigatory process would appear to be a common theme across most of the literature irrespective of agency. Studies show that the experiences of scrutiny for staff are perceived as predominantly adverse with only a few areas that identify factors that ameliorate the process for individuals involved. This is an overlooked element on the effects of suicide on staff and affirms that we need to better understand the experiences of nurses.

3.6 Blame and accountability

Appleby et al's (2006) national research study stated that all NHS organisations should learn from all suicides. The document confronts individual practitioners with an expectation that more could be done in relation to the risk management and assessment of those clients most at risk. They encourage staff to be more proactive in how risk can be managed safely and that suicide is not an inevitable outcome. They also argue that, before clinicians can be encouraged to be more robust in their practice, organisations must address the perceptions that individual clinicians will be blamed for their actions.

Various publications on patient safety argue that the most effective safety culture is one where practitioners feel able to report patient safety events in a climate that is free from blame (Reason 2000, Kohn et al 2001, Volpp K and Grande D 2003, Department of Health 2006, Department of Health 2007, National Patient Safety Agency 2008). The link between NHS staff feeling supported, valued and free from blame is seen as a key indicator in developing a workforce that will enhance the quality and safety of the service users experience (Department of Health 2009). These principles are important but some commentators would argue that a blame free culture is almost an anathema to working in the public sector where staff are exposed to multiple organisational variables that they may have little or no control over. Paterson (2008), in his analysis of how organisations learn from inquiries, cites Cartwright (2008) stating that the inquiry process *'reflects the natural human tendency to look for a scapegoat whenever great disaster is uncovered. The urge to blame runs deep'*.

Numerous studies, across a range of agencies, support Paterson (2008) assertion that during the investigatory process, from either internal or external inquiries personnel feel both blamed and personally accountable for the incidents (Chemtob et al 1989, Hill 1990, Rallings 2000, Gustavsson and MacEachron 2002, Wright et al 2006, Foley and Kelly 2007, Robertson et al 2010).

The literature reveals a tension between the concepts of accountability and blame. Alicke's (2000) literature review on blame outlines that within all social groups members are encouraged to maintain and adhere to the norms or acknowledged parameters of their respective group. Any subsequent transgressions from these agreed norms are then subject to scrutiny and or 'punishment' dependent upon the exact circumstances.

Accountability for ones actions is seen as a cornerstone of what constitutes a profession. Friedson (2001) outlines that this element is one of the defining

characteristics for professionals and sets individuals apart from those who claim to be professionals or are pseudo- professionals. Bovens (1998) suggests that this concept of accountability is blurred when there are systemic failings and often individuals are wrongly held to account for wider organisational deficits. Clark (2005) argues that, when errors have occurred, true learning only takes place where there is a mixed economy of both personal and organisational accountability.

Bovens (2005) takes a broader look at public accountability in a comprehensive analysis of professional accountability. He equates accountability with openness and transparency where the individual is obliged to explain or justify their actions. The issue of justification being most apparent where there has been an incident or error and heavily influenced by the dynamics of relationships. Brinkerhoff (2004) outlines that despite various definitions of accountability it actually remains relatively ill defined and this lack of clarity exacerbates mutual and agreed understandings. He goes on to say (page 372) that ultimately the '*essence of accountability is answerability.*' Brinkerhoff (2004) affirms Bovens' (2005) view of the importance of the context of the specific situations when accountability is questioned. He suggests that it can be viewed favourably as a determinant for performance and quality improvements. However he suggests that often accountability is only discussed in the context of adverse events and therefore is inextricably entwined with the allocation or accusation of blame. The personal assessment of the situation is important as identified by Crigger (2004 and 2005) who proposes a model where if individual staff accept their responsibility for contributing to an error or mistake then this will, overtime, reduce the likelihood of them feeling blamed. This may also lead to greater organisational responsibility and ultimately a heightened awareness from the general public that all public servants cannot attain a flawed expectation that they would be perfect on every occasion. These views and respective models appear laudable in supporting an organisational and individual culture of collective accountability. However it does not address where individuals feel blamed and do not believe that they have transgressed any professional or systemic policies or practices. Alexander

et al (2000) identify that even in the absence of any formal wrongdoing there can be a tacit expectation placed upon staff inferring that more could have been done to negate the incident occurring. This inference can then indirectly lead to feelings of 'self blame' being experienced by the worker. Mitchell (2001) suggests that for some professional groups there is a need to develop a greater understanding of professional accountability and in particular how this relates to their every day role. Ultimately the literature indicates that the experience of staff feeling blamed is a significant contributing factor in experiencing psychological distress.

3.7 The employer's response

It is well recognised that a pro-active and positive response from the employer may help individual staff members cope with difficult situations (Health and Safety Executive 2009). Therefore the importance of the organisations response is felt to be a crucial aspect in relation to the impact on staff both personally and professionally. Corneil et al's (1999) study of fire-fighters exposure to PTSD emphasised this point. The quantitative study compared staff in the 2 groups. They outlined how the reaction of workers to severe traumatic events is influenced by both personal factors and importantly how the organisation responded.

White (2000) undertook a comprehensive analysis of firearm incidents in the Philadelphia police service utilising a quasi- experimental design between two time periods. He considered the effects on police officers involved in firearm incidents whilst under different administrative policies. White's (2000) principle finding was the importance of robust organisational policies in providing clarity to police officers about the circumstances in which they can use their firearms, particularly in relation to the application of 'deadly force'. He suggests the absence of clarity and/or changes in organisational policy can leave police officers in an invidious position, potentially exposing them to greater stress and adverse criticism and inevitably the

potential for internal or external inquiries. There is a corollary here between what is described in the police service and the enormous policy changes in mental health services over recent years.

Further studies have identified how a positive response from the employer will negate the likelihood of adverse psychological response. Rallings' (2002) meta analysis of psychological trauma experienced by police officers outlines a four-phased strategy for improving how to predict the likely response of officers involved in traumatic events. This includes dealing with the aftermath of the inevitable scrutiny that follows serious events. He states that this strategy enables managers to put preventative measures in place that may negate potential adverse psychological responses. Table 3.4 identifies the strategies;

Table 3.4

Rallings' (2002) organisational support for police officers
<ul style="list-style-type: none"> • Identification of those individuals who are most likely to experience psychological trauma in relation to serious incidents, • Ensure psychological support for the individual is available immediately after the incident and post event • Implementation of specialist selection criteria before placing police officers in units that are more likely to experience repeat exposure to traumatic events.

From a health perspective Valente and Saunders (2002) support such a model and emphasise the importance of support mechanisms for nurses following critical events. Whilst there is merit in the need to support staff Rallings advises on reducing the likelihood of exposure to trauma may not readily transpose to mental health nursing. However it is of relevance to consider whether the participants in this study may be more or less exposed to unexpected death or suicide dependent upon their clinical environment.

3.8 Previous experience

The final element of common ground across various occupational studies is the importance, or otherwise, of previously experiencing similar events. Hodgins et al (2001) comment on exposure to previous events has a positive or detrimental effect on how the experience is received i.e. whether it is interpreted as a stressful event. Renck et al's (2002) study of 41 police officers uses a battery of self report measures to determine levels of psychological distress following adverse events. They identify that officers exposed to stressful events develop an 'immunity' following repeat exposure. Contrary to this Stephens and Miller's (1998) survey of 527 police officers found that the greater the number of different traumatic events experienced by police officers the more likely symptoms of PTSD would be present.

Similarly a number of studies have been undertaken to evaluate the impact on stress in relation to emergency personnel, notably ambulance workers and fire fighters. In a study of 110 ambulance personnel Alexander and Klein (2000) identify that experience of traumatic incidents does not necessarily mean that the worker learns to cope more. Their study was designed to understand whether exposure to previous incidents and emotional wellbeing were related and to identify if psychological hardiness is a protective factor in mitigating the potential development of occupational trauma. The questionnaire was developed utilising various standardised tools including the General Health Questionnaire, the Impact of Event Scale and the Maslach Burnout Inventory. Their findings suggested that the worker is less likely to admit emotional difficulties because they feel others around them expect them to cope. A further compounding factor was anxieties about career prospects if not seen to be sufficiently emotionally resilient. Similar studies (Robinson 1993,) have also suggested that senior staff are less likely to report they are in need of support and may experience the effects of cumulative stress rather than the effects of a single severe incident. Bennet et al's (2004) survey of 617 ambulance personnel, using measures including the Hospital Anxiety and Depression Scale, argue the issue of

seniority is not borne out. They suggest that length of service is a factor in whether an ambulance worker may develop a severe stress reaction. They argue that a cumulative and progressive exposure to incidents increases the likelihood of developing an adverse reaction. Laposa and Allen (2003) identify that, for Accident and Emergency personnel, no such conclusion can be drawn and that years of experience are neither a protective or negative factor in the likelihood of experiencing a severe stress reaction to an adverse event. They suggest that the cognitive processes of the member of staff are the defining factor, essentially how the individual personally interprets the situation. However frequent exposure to severe events as faced by emergency personnel, that are outside of the experiences of the 'normal' community, have a clear link to the likelihood of experiencing a severe stress reaction. Beaton et al (1999,) in a study of fire-fighters and paramedics, found that neither the participants years of service or exposure to traumatic events correlated significantly with the likelihood of developing a formal diagnosis of PTSD. This finding supported the earlier works of McFarlane (1989) who, contrary to his initial hypothesis, found that neither the extent of the exposure to the major incident or the losses involved provide any significant predictor of the likely onset of a pronounced psychological reaction to the adverse event. Lindahl (2004), in a review of PTSD and case law pertaining to fire rescue workers, indicates that the gradual cumulative effects of stressful events is something that employers should be cognisant of when considering the mental well being of their workforce.

Hyman (2004), in contrast, suggests that the severity of prior events can be a predictive factor particularly when considering the categorisation of intrusive thoughts often experienced by those who have a diagnosis of PTSD. Hagh- Shenan et al's (2005) identify that training and experience can mitigate the impact of psychological distress on rescue workers. They highlight how rescue workers, who had little or no training in disaster work, are more likely to experience post traumatic stress disorder.

The evidence on the importance of previous experience is mixed. Some studies argue it may be beneficial whilst others say cumulative experience can be detrimental. What is particularly interesting is that staff do not always feel able to express how they feel about their experience. This may be due to a range of anxieties including the fear of adverse response from colleagues or employers.

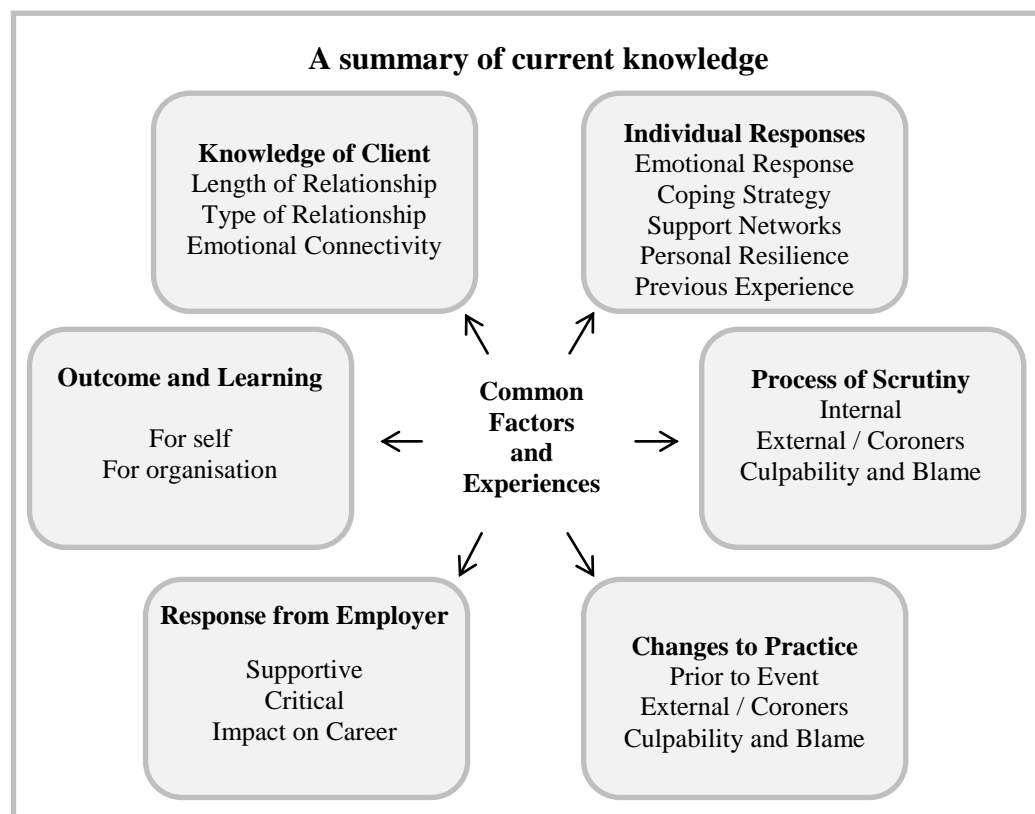
3.9 Summary of current knowledge

The review of the literature related to working with illustrates that, for those professions outlined above, including, health care workers, social workers, police officers and emergency personnel psychological stress can occur as a direct result of their role. Studies that have been undertaken do not routinely pay homage to other research where the evidence suggests there may be some similarities across differing workforces. Therefore this rather disparate set of studies on differing occupational groups provides some synergies when one considers them as a collective phenomenon. The literature on ‘second victims’ also provides insight into the potential experiences of staff following an adverse event. These themes include, the investigatory process in response to the event, the psychological response of those involved, what mitigates against an adverse reaction from the employee and how the organisation responds.

The findings allow the opportunity to develop a summary of current knowledge and to organise common themes and experiences that emerge from the broader studies. This representation is not offered as a model or theory merely a mechanism for arranging the disparate findings. Figure 3.2 outlines some of the common factors that are summarised from the various studies. It is developed based upon the experiences that emerge from the literature on psychological trauma and the effects of professional scrutiny.

Drawing upon the literature review and Figure 3.2, various areas emerge that have not been previously considered in the nursing literature. Most obviously is a lack of studies that consider the experiences of nurses after a suicide or unexpected death. Those studies that have addressed this have not considered in detail the effects of professional scrutiny on the nurse. Non-health related literature states that this process of scrutiny may have a major impact on the individual. I argue that this is a notable omission in the mental health nursing literature. Second victim literature identifies some psychological consequences for staff after an incident. However they rely heavily on the admission of error by the staff, something that may not be evident in mental health services. Furthermore I could not locate any second victim studies that specifically consider mental health practitioners.

Figure 3.2



The review also identifies inconsistencies in whether previous experience to similar incidents is a beneficial or not. The literature is inconsistent on how important the relationship with the deceased is; specifically whether nurses, by the nature of their role, are more likely to experience psychological distress.

3.10 Conclusion

The literature review identifies a diverse series of studies across a range of occupational groups, that begins to articulate the collective experiences of those who have been subject to scrutiny due to the accountability associated with their professional roles and unexpected deaths. The review also notes the effects of occupational stress and for some groups the manifestation of significant debilitating psychological disorders that imprint on both their personal and professional lives.

To understand the collective experiences of the studies I have developed a visual summary to organise the themes that emerge from the studies. It combines the disparate studies to try and understand the collective experiences of staff arising from the literature. This is important as it affirms the need for further study. It demonstrates that the knowledge regarding experiences of staff arising from unexpected death and suicide can be assimilated into one previously unrecognised framework.

The analysis of the literature affirms the absence of studies that address the specific experiences of mental health nurses in relation to unexpected deaths, suicides and the subsequent process of professional scrutiny. The literature consequently informs the need for the chosen methodology to be sensitive and mindful of the potential experiences of the selected participants.

Chapter four will provide the rationale for the methodology utilised within this study. Ultimately it was informed by the studies expectations to facilitate a detailed understanding of the experiences of mental health nurses.

CHAPTER 4

METHODOLOGY

4.1 Introduction

This chapter will establish the aims and objectives of the study and the rationale for the research design and methods. The chapter will also include how the sample and sites were established, the preliminary work undertaken prior to the commencement of interviewing participants and how data was analysed. Methodological rigour was achieved by adhering to recognised frameworks for qualitative studies (Green and Thorogood 2004, Burns and Grove 2005). Finally I outline how relevant ethical issues and research governance requirements were appropriately discharged through the study.

4.2 Research aims and objectives

The literature review identified a disparate series of studies across a range of occupational groups that identifies the experiences of those who have been subject to scrutiny due to unexpected deaths. The review also noted the effects of occupational stress, including for some, the manifestation of significant debilitating psychological disorders that imprint on both their personal and professional lives. The literature consequently informs the studies need for the chosen methods to be sensitive and mindful of the potential experiences of the selected participants.

The choice of research design was informed by the desire to facilitate a detailed understanding of mental health nurses experiences regarding the effects of

unexpected death and suicide and in doing so enhance the growing body of research on occupational stress within the health and social care professions. The study is specifically interested in the previously unrecognised experiences of nurses who have been subject to professional scrutiny arising after a suicide or unexpected death.

To enable a meaningful understanding of the experiences of the participants a qualitative approach was favoured. A grounded theory methodology was selected as it ensures the understanding of collective experiences of individuals, whilst providing a rigorous framework for the collection and analysis of data, and the development of theory (Charmaz 1995).

The study aimed to:

Understand the experience of mental health nurses who are closely involved with a patient who dies unexpectedly or commits suicide and are involved in any subsequent investigation or inquiry.

Specific objectives were to:

1. To understand the psychological and social impact on the nurse of the unexpected death or suicide of a client and its aftermath.
2. To understand the nurse's adjustment process and factors that influence that adjustment.
3. Describe the impact of the client's death and its aftermath on mental health nurses' professional practice.

4.3 Research design and methodological considerations

This section will outline the research paradigm for the study and seek to place the research within a recognised theoretical framework. Bowling (2004 page 352) emphasises that the strength of qualitative inquiry is the ability to study people within their own world and '*obtain a great deal of in-depth information*'. A qualitative methodology appeared most consistent with the research aims and objectives and the need to understand the deconstructed then reconstruction of the nurses' experiences.

This study is situated within an epistemological paradigm of constructivist grounded theory and interpretivism. During the development of the study I was cognisant of the differing forms and historical developments of grounded theory (Glaser and Strauss 1967, Strauss and Corbin 1990, Glaser 1992 and Charmaz 2008). I decided that socially constructed grounded theory espoused by Charmaz (2011) was to be adhered to within this study

Constructivism is a social scientific perspective that addresses how realities are made. This perspective assumes that people, including researchers, construct the realities in which they participate. Constructivist inquiry starts with the experience and asks how members construct it. To the best of their ability, constructivists enter the phenomenon, gain multiple views of it, and locate it in its web of connections and constraints. Constructivists acknowledge that their interpretation of the studied phenomenon is itself a construction. As such, Constructivism 'assumes the relativism of multiple social realities, recognises the mutual creation of knowledge by the viewer and the viewed, and aims toward interpretive understandings of subjects' meanings' (Charmaz, 2000a, p. 510). Charmaz (2000a) argues that traditional, 'objectivist' formulations of the grounded theory methods, view grounded theory as the discovery of categories inherent in data, observed in an external world by a neutral observer. Arguing that such a position is no longer tenable given the

‘interpretive turn’ (Denzin & Lincoln, 2000) in qualitative social scientific research, Charmaz (2006, p. 178) posits a Constructivist stance in which: “we can view grounded theories as products of emergent processes that occur through interaction. Researchers construct their respective products from the fabric of the interactions, both witnessed and lived.”

Charmaz (2000) therefore identifies that the constructionist approach does not seek ‘truth’ but, she argues, identifies the true reality or perspectives of the participants’ experience. She identifies that all knowledge is ‘situated knowledge’. The priority is on the phenomena and the identification and analysis of data through the shared experience and relationship with participants. This theoretical approach differs from the objectivist perspective, which is more closely aligned with positivist traditions. Charmaz (2011) encourages an approach that enables the researcher to be flexible and reflexive by utilising a series of principles that facilitates a rich and detailed analysis of the participants experiences. Those principles, including research design, data interpretation and analysis are described in more detail below.

Grounded theory (Charmaz 2008) was therefore considered as the preferred method for the design of this study. The systematic yet flexible approach enabled me to be sensitive to what participants were saying and develop and test theory through the duration of the study. Corbin and Strauss (2008) argue that grounded theory provides a fluid, evolving and dynamic format which is preferential when trying to understand that the collective experiences of participants that will be complex and previously undiscovered. Burr (1995) also argues that a social constructivist approach allows an opportunity to critically appraise our understanding of the world that we may take for granted. As a Director of Nursing with twenty five years experience of working within mental health services I wanted to both set aside any preconceptions I may have about the study whilst using experience for a greater understanding of the participant’s world. This personal and philosophical perspective aligned itself most closely to the theoretical framework of constructivist grounded theory. I am

cognisant of the criticisms of qualitative research and specifically grounded theory (Wasserman et al 2009, Urquhart et al 2010). However I am not persuaded by these arguments and will establish how I ensured this research is robust.

The constructivist approach argues that knowledge is locally constructed from the experiences of either individuals or groups. It places significant importance on the social context of the individual, which in the genre of this study, pertains to the unexpected death or suicide of a client and the aftermath for the nurse. This was an important facet of the study that would ensure I was able to gain a rich understanding of the collective and reconstructed experiences of nurses who shared a similar social process. For my participants this social process and phenomena was how they responded to the death of a client and what the personal and professional consequences were for them. Charmaz (2008) affirms that constructivist grounded theory places priority on the collective phenomena of the study and from this one can elucidate new and emerging theory. Charmaz (2000) further challenges the objectivist approach of earlier proponents of grounded theory. She argues that a richer understanding of the participant's experiences is derived from the researcher's interaction within the field of study and the constant questioning of the data.

This study follows Charmaz's (2008) approach and challenged me to reflect on any potential preconceived ideas I may have and therefore any interpretations I might draw from the experience of the participants' world. I found this philosophically very appealing as it enabled me to use my experience as a starting point and initially shape the emphasis of the study. However it also facilitated me to scrutinise the data and develop theory from the actual realities of the participants and shed any preconceived ideas.

The social constructionist approach facilitates the researcher having an enriched understanding by facilitating probing and searching interviews which can reveal the deconstructed experience of the participant (Flick 2004). I wanted to ensure that I

was able to engage the participants where they felt invited to join in a conversation that ultimately seeks to make sense and give significance to their world. I wanted to ensure the study was not merely a description of individual experiences but an account of their collective social phenomena (Greene 1998, Gergen1999). This approach facilitates a greater understanding of the experiences of the participants and allows for a proactive and positive engagement with the researcher. These collective perspectives provided a compelling argument that I should adopt this approach within my study.

4.3.1 Sample and Sites

A purposive sampling strategy was used to derive the study sample and specifically identify a homogenous sample type (Kuzel 1999). Given the specific nature of the research this sampling strategy ensured that the nurses had the same characteristics. The specific characteristics of the participants were;

- 1- To be a registered Mental Health Nurse.
- 2- To be employed within a Mental Health NHS Trust.
- 3- To be involved in the care of a client who had committed suicide or died unexpectedly.
- 4- To have been involved in a process of professional scrutiny regarding the clients care specifically including attending a coroners court.

Whilst there is no definitive guidance for the sample size within a qualitative study it remains an important aspect particularly when one is seeking to explore a socially constructed experience. Therefore I felt it imperative to review what was available to guide me in my decision on the size of the sample. Certain authors suggest that within homogenous sampling method six to eight participants is sufficient to obtain credible data (Kuzel 1999, Onwuegbuzie and Collins 2007, Onwuegbuzie and Leech 2007). Miles and Huberman (1994) suggest that anything over this sample size is

sufficient to attain new knowledge within the context of an area that has a paucity of research. Glaser (1998) and Stern (1994) support the principle that in areas that are poorly researched and within the context of grounded theory methods smaller samples sizes facilitate a rich and detailed understanding of the complexity of the participants' world. They argue studies and sample sizes should be defined, the richness of the data derived from the individual rather than bound by a notional number of participants. In determining size Corbin and Strauss (2008) reiterate that the skilled researcher will also determine, through the iterative nature of grounded theory, when saturation point has been reached through the recurrent and repeated themes that emerge from participants. Cognisant of these views this study sought to identify a suitable cohort of staff to provide sufficient data. Ultimately fifteen nurses (n15) were identified to participate in the study.

The study was undertaken across a number of Mental Health Trusts (4) within the health boundaries contained in the East of England Health Authority. For the sample of nurses who attended a coroner's court it was proposed that the sample would have two principle exclusion criteria namely:

- 1) Any nurse who has attended court within the last six months
- 2) Any nurse who attended court over three years or more

The rationale for the exclusion criteria is two-fold. Firstly to negate that the experience may be so current as to potentially re-traumatise the nurse should their court appearance has been a particularly difficult experience. The component of timing is felt to be essential in qualitative research (Cowles 1988). McCosker et al (2001) outline the importance of keeping participants 'safe' from the psychological impact of research and the possibility of exposing them to harm or distress. They suggest that timing can be extremely important and affirm the importance of clear explanation of the study to all participants to negate the likelihood of adverse reaction to the study. Secondly, and of equal importance, was to ensure that their

recollection and memory is relatively current. Polkinghorne (2005) provides a comprehensive review of selecting an appropriate sample to maximise the efficacy of the study. He argues the importance of obtaining a 'rich narrative' from participants and the need for them to be able to advise on their rich and refined experience. Therefore cognisant of this perspective a decision was taken that after a period of three years the experience may not be sufficiently timely to provide accurate recall of the events.

All the selected Directors of Nursing have clinical risk management as part of their portfolio. Therefore they were in a position to identify whether they could commit to the study and the potential numbers of participants. The Directors contacted potential participants with information on the study. At the requests of the Ethics Committee this included a introductory letter from the relevant Director of Nursing inviting them to consider participating in the study but emphasising this was entirely voluntary (Appendix 2). Participants also received an information sheet, which explained the rationale for the study including implications for participating and clarity on confidentiality (Appendix 3). All participants, who expressed an interest in taking part, were included. Therefore there was a clear element of self-selection from those willing to participate in the study.

4.3.2 Preliminary work for interviews

Qualitative interviewing enables the participant to identify what they think is important and relevant about their personal and social environments. Bryman (2004) identifies how semi-structured interviews enable a framework to be developed that assists the researcher but has sufficient latitude for participants to take the direction they feel is relevant. The interviews were conducted utilising an interview guide (Appendix 4). The interview guide was initially developed prior to the study. This process involved interviewing two colleagues at work. This provided an opportunity

to practice the initial questions, further develop interview skills and refine the initial framework of the interview guide. Following the pilot and in consultation with academic supervisors the guide was further refined to promote more detailed responses from participants. This iterative approach was an important aspect to ensure the study was sensitive enough to respond to the collective experience of individuals.

The guide enabled the interviewer to collect similar types of data and follows an agreed line of inquiry which addressed the research aims and objectives (Holloway and Wheeler 2002). Kvale's (1996) ten-step framework for ensuring successful interviews was used to guide the dialogue in order to facilitate meaningful discussions. Importantly, from a social constructionist perspective, Kvale's (1996) criteria on interpretation allows for the sufficient expansion of ideas which fall within the philosophical perspective of this genre. This facilitated a detailed response from the participants whilst recognising and being sensitive to areas of discussion that may cause them distress. As will be evidenced in the findings section the use of Kvale (1996) criteria was beneficial in guiding the participants to a position where they gave detailed disclosures of their experiences. Each interview lasted approximately sixty minutes and was recorded with the respondent's permission.

Charmaz (2008) affirms the importance of planning the interviews carefully ensuring a grounded theory approach narrows the range of the interview topic whilst facilitating a depth and richness to the data.

4.3.3 Involvement of participants

Fifteen Nurses (n15) from all four of the mental health trusts responded to the request to participate in the study as identified above. Participants contacted the

researcher to initially discuss the study and arrange interview dates and locations. The relevant Director of Nursing was also asked to provide suitable accommodation for the interviews. This ensured that the environment was appropriate and conducive to confidential interviews. This also facilitated the participants feeling relaxed and comfortable in their surroundings, a prerequisite for successful qualitative interviews (Burns and Grove 2005). Most of the participants interviewed identified that their own work place had a suitable room for a confidential interview to take place and they were happy to meet at this location. Two of the participants requested that the interview take place outside of their immediate work environment. In both cases this request was due to their work base having inadequate facilities to enable a confidential research interview to take place.

4.3.4 Methods and Data analysis

The epistemological position of constructionist grounded theory ensures that the adherence to a recognised analytical framework will drive the researcher to actively engage with the data. It was this aspect of active engagement with the data and the participants that was one of the most compelling motives for using this approach. The data was repeatedly scrutinised looking for emerging codes then categories. It involved a dynamic and consistent comparison of the data that looked to affirm or deny emerging theories. This required repeatedly going back to the data to critically re-examine to ensure theories that emerged were relevant and therefore appropriate conclusions drawn. This approach meant at times that theories I believed to be emerging were disproved on closer analysis. This persistent interactive process provided rigour and ensured the theory development emerged from the data and was not driven by any potential assumptions. The sections below provides the reader with specific detail of how data was analysed utilising a recognised grounded theory process (Charmaz 2008).

Transcripts were analysed utilising a recognised grounded theory process (Charmaz 2008). This commenced with by line-by-line open coding of the data. This initial coding enabled swift understanding of the data plus informed lines of enquiry for further interviews. The open coding enabled the commencement of early examination of the data with the emergence of potential categories. After completing the initial open coding data was reconstructed using axial coding to make connections between emerging categories. Corbin and Strauss (2008) advocate the importance of axial coding in making data more coherent and therefore an important element for allowing the researcher to understand the concepts and theories that are evident. To ensure that my analysis was consistent with social constructionist process the themes informed an interaction between participants and myself as the researcher. Essentially this ensured that, as the researcher, I was connecting with the accounts and experiences of the individuals. Each interview was a further opportunity to question and compare the data from previous interviews. This enabled, that as theories emerged, they could be tested further with the participants. Immediately after each interview I would also write keynotes that seem to develop from the interview. This would include both verbal and non-verbal aspects. e.g. if the participant became tearful, upset or asked for a break during the interview.

Memo's as identified by Charmaz (2008) were also utilised to help generate codes and conceptual categories as part of further process of analysing the data. This provided me with an opportunity to reflect on the interviews and move beyond initial early descriptive codes to the development of the categories. The transcripts were subject to constant comparison and questioning to rigorously scrutinise the data. In line with the recognised framework theoretical sampling was utilised to ensure data moved from description to analysis and thus brought clarity to the categories. It ensured that the data was subject to both conceptual and theoretical development. Corbin and Strauss (2008) identify that the aim of theoretical sampling is to maximise opportunities to compare events, incidents or happenings. This process of objectively considering individual accounts and scrutinising data for categories and

sub categories was consistent with qualitative analysis in grounded theory. This iterative sampling process continued until I felt saturation was reached. By the twelfth interview very little new data was emerging although to ensure saturation was fully reached a further three interviews were conducted ultimately concluding with fifteen interviews.

An important element of the data coding and analysis process was the interpretation of the identified categories and sub categories. An equally essential requirement of this method of analysis required me to go beyond the word and challenge the data to reveal its true meaning. This facilitates an expansionist approach, which enables the researcher to develop theory and represent 'reality', which brings meaning both to the researcher and the participants. Transcripts were analysed between interviews therefore I was able to test emerging theories on new participants to identify consistent categories. This questioning and challenging of the data is consistent with grounded theory and social constructionism (Charmaz 2008).

4.4 Methodological rigour

It has been argued that within the social constructs of research, there are no absolute 'truths' and social scientists suggest there can and should be several accounts which can bring meaning to the same area of study (Bryman 2004). Despite these tensions it is a prerequisite that the reader of the research should be able to judge the findings as credible, and to such an extent that this could be applied across the same or similar social or cultural populations. To maintain rigor within the research process I adhered to frameworks for 'good practice' which can add credibility to analysis (Green and Thorogood 2004, Burns and Grove 2005)

4.4.1 Transparency

I have outlined above within the data analysis section, the methods used to gather data and generate theories. This involved interviewing fifteen nurses and, using a combination of inductive and deduction methods, I moved between the data and interviews searching for new or emerging theories. This process of theory generation and data analysis was undertaken using well established methods (Corbin and Strauss 2008, Charmaz 2008). This incorporated coding data, developing concepts and building and then testing theory, concluding when saturation point was reached and no new data emerged. Appendix 5 illustrates theory generation and data analysis.

4.4.2 Descriptive vividness

It was important to give consideration to how my interpretation of the data and experiences of the nurses could be seen to both credible and legitimate.

Within this study I utilised a number of mechanisms for ‘validating’ my findings namely;

- Debating my findings and their meanings with my academic supervisors to establish whether my interpretation of the experiences of the nurses was logical and well structured. This included sharing transcript and coding of transcripts. This also extended to discussing findings from interviews and agreeing how to modify or test tentative theories at subsequent interviews. This element was also an integral part of testing my emerging propositions and determining whether my interpretation of the findings was logical, well ordered and credible.
- During subsequent interviews I would ask questions informed by my early tentative analysis.

- Whilst immersed in the transcripts I would look for accounts that may disprove, discredit or contradict some of my early theory development. I present this further in the findings chapter to demonstrate, where some participants may have experienced one reality, it was not necessarily consistent for the whole ‘social group’

This process afforded a vehicle for ensuring that the findings and conclusions that are drawn are consistent with recognised frameworks in qualitative research.

4.4.3 Repeatability

Within the context of this study reliability equates to repeatability and whether the findings would be repeatable if undertaken within similar circumstances and a utilising the similar social group of participants. Charmaz (2008) suggests that this means that the researchers should leave a clear audit trail of how they undertook their work and how they arrived at their findings. To adhere to this requirement I would regularly share with my academic supervisors key findings emerging from the data. This was then subject to challenge, scrutiny and acted as the role of ‘auditor’ in ensuring that findings were dependable and transferable. This process included reviewing and challenging methods of data collection and analysis, considering memo notes and reflecting on each step of the process. Specifically this also involved reviewing initial transcripts and how data, subsequent findings and emerging theory were derived. This ensured a clear ‘log’ of decisions was available for review to revisit decisions taken and the relevant rationale.

To ensure ‘reliability’ within this study interviews were recorded and transcripts were typed in full unedited. Data was coded using principles that are deemed to be in accordance with the established practices of grounded theory research. Findings

were further tested and scrutinised by myself, my academic supervisors and participants as part of the inductive element of the study.

4.4.4 Analytical, theoretical and heuristic relevance

The whole ethos of this study was to constantly compare new and emerging findings within the data. The selection of a grounded theory study was to deliberately facilitate an approach that would truly engage with the data and the collective experiences of the participants. The fluid nature of the study enabled a dynamic way of interacting, constantly comparing the data and refining the theories.

4.4.5 Reflexivity

The importance of undertaking a reflexive approach is reiterated by numerous authors including Charmaz (2008), Burns and Groves (2005) and Corbin and Strauss (2008). I was particularly sensitive to this aspect and to ensure that I should not draw undue inference or inappropriate assumptions based upon my experiences rather than the participants' collective accounts. An early example of a possible tension within the study and the need for a reflexive approach was whether I would declare my role as a Director of Nursing to participants. This was discussed with my supervisors as both an ethical and technical conundrum about how this may potentially influence the dynamics of the study. It was agreed that a completely transparent approach was appropriate and that I would seek to reassure the participants if any anxieties emerged.

This 'tension' of using my own knowledge without prejudicing the study was a constant and continuous thought throughout the whole study. Therefore I would routinely seek to vociferously review the data to ensure that I was accurately drawing

the correct conclusions and not unconsciously superimposing any preconceived ideas.

4.5 Ethical issues and research governance

It was an essential requirement of the study that participants would not be harmed by the research and full informed consent was sought (Robinson and Thorne 1988, Flinders' 1992 and Beauchamp and Childress 2001). All interviewees were provided with a full explanation of the study and received written confirmation of the aims and objectives. This was provided in the form of a participant information pack (Appendix 3). This included how the data would be used and stored. Potential participants were also assured of confidentiality, anonymity and offered time for further explanation should they so wish. Each participant was provided with an opportunity to have a copy of their transcript to ensure they felt that the true nature of the dialogue was reflected.

Newman and Kaloupek (2004) provide a sanguine reminder about the importance of ensuring that participants who are participating in research should be supported. They suggest that researchers must be cognisant of the potential to re-expose participants to trauma and arouse strong emotions. Therefore given the sensitivity of the discussions in this study and the potential for distress, the Directors of Nursing in each Trust were asked about local support mechanisms for staff should the need arise. These details were available at interview should participants feel they required this additional support.

Data was stored in a locked cabinet with access restricted to the author only. This process was outlined to participants and formed part of providing additional assurance when obtaining their written consent to participation in the study. The consent process was not static and in recognition of the recommendations of Ford

and Reuter (1990), the author ensured each participant consented with the study. Consent was recorded in writing in accordance with National Research Ethics Guidance.

This research study was implemented across multiple NHS sites within the East of England. The research was, therefore, conducted in accordance with the National Patients Safety Agency, National Research Ethics Service (NRES). The proposal was submitted on the NRES application form to the Essex Local Research Committee (the author's area) and approved in September 2009 by the Essex 1 Research Committee. The study also required a site-specific assessment. The study was therefore undertaken in line with all national, regional and local research governance best practice principles.

4.6 Conclusion

This study has required interviewing staff that have experienced the death of a patient and been subject to professional scrutiny. The limited nursing literature affirms that the method for further studies should be sensitive and mindful of the potential experiences of the selected participants. I was also keen to ensure the selective methods and research designs were credible and dynamic enough to respond to the developing nature of the collective accounts of the participants. A grounded theory approach facilitated a vehicle for developing and testing theory in this area where there is thought to be a paucity of previous work.

CHAPTER 5

FINDINGS

5.1 Introduction

This chapter will set out the findings that emerged from interviews with mental health nurses. The purpose of the study was to understand the experience of nurses whose client died unexpectedly or committed suicide. Importantly this study also sought to understand the impact of the process of scrutiny in the aftermath of the deaths. Section 5.2 sets out the characteristics of the respondents. Section 5.3 sets out the findings from the respondents in relation to the objectives of the study (specified in section 4.2). To aid the reader Section 5.3 organises the findings into three sections, namely;

- 1 The psychological and social impact of the unexpected death or suicide of a client and its aftermath.
- 2 Factors that make nurses either more or less susceptible to experiencing an adverse psychological response.
3. The impact of the death and its aftermath on mental health nurses' professional practice.

Due to the size of the chapter, to further assist the reader, each section commences with a synopsis of the main findings. This is to enable the reader to have a broad understanding of the detailed findings that follow. Each sub section also includes a brief summary of the relevant findings.

5.1.1 Summary of findings

The findings demonstrate that the unexpected death or suicide of a patient had, for many, a profound effect on the mental health nurses involved. These effects included a variety of psychological and emotional experiences, which for some have an on-going impact on their lives. Many of them describe how the effects of the incident transcended their home lives. Some of the nurses spoke about the incident for the first time other than discussions with their employer. They gave open accounts of the personal distress that many of them experienced. This included not only dealing with the aftermath of the death but, for some, the ongoing contact with the deceased's family. The nurses also described how the death and the subsequent process of scrutiny impacted on their clinical practices. Participants also shared what they felt was beneficial in supporting them through the process and what else they felt would ameliorate other nurses being exposed to this level of occupational stress. This included accounts of how employers may improve their support to mental health nurses in the challenging environment in which they work.

5.2 Characteristics of participants

Participants in the study (n 15) had a variety of experience working as registered nurses with a mean period of 13 years post registration experience, and a range from 1 to 30 years. The nurses worked across a variety of mental health services including adult acute in patient services, drug and alcohol services, early intervention teams, community mental health teams and community forensic services.

Table 5.1

Characteristics of the participants

Name of Participant (pseudonym used)	Role	Length of Experience
Barbara (01)	Community Nurse Drug and Alcohol Services	16 years
Michael (02)	Community Nurse Drug and Alcohol Services	1 year
John (03)	Nurse Manager	21 years
Frances (04)	Nurse Manager	30 years
James (05)	Community Nurse	4 years
Lisa (06)	Community Nurse Drug and Alcohol services	15 years
Mathew (07)	Community Nurse	19 years
Sally (08)	In patient services	2 years
Sarah (09)	Community Nurse Drug and Alcohol Services	15 years
Janet (10)	Community Nurse Drug and Alcohol Services	11 years
Jasmin (11)	Inpatient Services	10 years
Helen (12)	Community Nurse	10 years
Jacky (13)	Community Nurse	6 years
Martin (14)	Community Nurse	26 years
Jo (15)	Community Nurse	7 years

The nurses worked in a number of differing clinical positions within their respective organisations. For some this included managerial responsibilities for several clinical teams spanning a wide geographical area. Five of the participants worked as community nurses in drug and alcohol services and of those, four had experienced more than one unexpected death or suicide. Additionally two senior nurses in adult mental health services had also previously experienced more than one unexpected death or suicide as part of their career.

The remainder of participants (n=9) had no direct previous experience of clients dying unexpectedly. The majority of participants were female (n=11) with a spread of nurses working across all ranges of clinical and managerial positions. Finally all of the nurses had, at some stage, worked within inpatient services as part of their initial professional development. Therefore some of the cases they shared were based upon working in both inpatient and community settings.

The client group discussed also represent a homogenous group in terms of clients who would be routinely known to mental health services due to the nature of their diagnosis. The clients referred to by participants experienced various mental health issues including schizophrenia, depression, bi-polar disorder, drug and /or alcohol dependence and personality disorder.

5.3 Section 1- The psychological and social impact of the unexpected death or suicide of a client and its aftermath

5.3.1. Introduction and synopsis

All participants provided a personal account of their experiences in relation to the death of a client. Their accounts detailed their experiences from hearing the news of the death of the client, the effect of this on their own emotional wellbeing, including

initial reactions through to longer-term effects. Their accounts also detail some particular areas that are noteworthy including the type of relationship they had with both the client and the client's carers or family

The consequences of an unexpected death or suicide on the psychological and social impact on mental health nurses can be profound. Participants highlighted that for all involved in this study they experienced psychological, behavioural or emotional phenomena that would be indicative of varying levels of anxiety and distress. For two of the participants there was evidence that the experience left them with some thoughts and behaviours more associated with PTSD.

The level of psychological intrusion varied for individuals but there are clear indicators of significant events that heighten or exacerbate the presence of the phenomena. Furthermore other potential indicators of how the death may impact on the nurses include the strength of relationship with the patient notably the emotional connectivity. Many participants revealed that when they have a close relationship with the client it has a detrimental impact on their own emotional wellbeing. Participants expressed a range of psychological responses to the death including feelings of sadness, anger and regret.

The nature of the relationship with the family and carers of the deceased can also ameliorate or enhance the likelihood of experiencing adverse psychological response to the events. Positive comments mitigate the likelihood of adverse effects. Conversely relatives who appeared unhappy or angry about the care the patient received exacerbated the impact on the nurses notably when this involved scrutiny through the auspices of the coroner's court.

Nurses described how a factor that mitigates the possibility of a severe adverse effect is to share their experience with someone they believe understands what they are going through. This understanding or empathy can come from either colleagues or

friends and families. In the absence of this, nurses may be more inclined to hide or mask how they are feeling. This includes for some, an unwillingness to share with colleagues that they are experiencing ongoing consequences of the incident.

Finally much of the psychological and social impact on the nurses would go unrecognised by their employers. This was due to either the nurses seeming to deliberately mask the impact of the events from their colleagues or that employers did not obviously recognise the impact on the ongoing wellbeing of their staff.

In order to make sense of their accounts, the experience of the nurses and the subsequent findings, this section will detail the main categories that emerged from the data.

5.3.2. The immediate response to the incident

The participants' initial response to the death was, in part, determined by the precise circumstance of the incident. Nurses interviewed worked in either community or an inpatient settings. Their initial response to the incident differed dependent upon the clinical circumstances of the nurse. The difference was determined by the fact that nurses from inpatient services were describing events when they were directly involved in the death on the ward. Community nurses were not present at the immediate time of the death. Their clients died in a range of settings including the clients' own homes, general hospitals, public places and prison. Those working within inpatient settings had, therefore, dealt not only with the death of a client but were directly involved in trying to maintain the life of the client at the time of the suicide attempt.

Those nurses working in a ward environment described in detail their particular experiences when they found a patient dead or dying. Their accounts differed from

others in that their starting point for their experience of the unexpected death or suicide commenced with managing the actual incident and death of the client. This group of nurses outline a specific set of circumstances that detail both the emotional and psychological effect of the incident combined with managing an extremely challenging clinical situation.

Sally (08) at the time a staff nurse on an acute inpatient ward, described how she felt when she was trying to resuscitate a patient who was not making a sustained recovery when undergoing cardio pulmonary resuscitation;

“I mean when it was happening my knees were shaking, you feel a bit sick you know usual thoughts because you can see at times that the lady looked dead at times and it was difficult because every time we got her back she kept going again.”

This quote highlights the physical reaction to what was happening during this stressful and traumatic event. This feeling was not uncommon and other nurses described immediate feelings of shock, panic, acute anxiety, concern and then distress. These feelings would also manifest in a behavioural response. A number of nurses described how they felt nauseous, tremulous, light headed and tearful. Their accounts outline how they would implement the physical interventions in trying to keep the patient alive. This could include, dependent on the circumstance, trying to resuscitate the patient, attempting to remove the ligature, using pharmaceutical interventions as part of the resuscitation and dealing with the physical aftermath of the body such as blood, urine and faeces.

Reactions from inpatient nurses, involved in the immediate management of the clinical situations, provided an insight into some of the challenges they faced in coping with the incident. The responses from inpatient nurses set out a range of common experiences. They described their immediate shock at finding the dead or dying patient and how they responded to this situation.

Jasmin (11) describes the impact on junior staff she witnessed when managing the incident.

‘ it was very strange first of all you’ve got to believe that when these things happen you’re in denial at this stage and there was this student nurse who knew the gentleman’s wife you know she knew the family really well and she was very upset and I went and spoke to her, she was in tears..... ’.

Her quote seems to identify that at first she was finding it hard to believe that this was actually happening. She also highlights how upset the student was inferring perhaps that this was in part because she was close to the family.

Nurses also described how, despite these feelings, during the initial attempts to save the life of the client a level of ‘automatic response’ occurred whereby they focussed on dealing with the clinical needs of the patients. Some described how they moved from initial shock, to an automated response, to the subsequent feelings described above after the clinical situation was dealt with.

One can see from Sally’s (08) quote about how she felt after the initial incident;

“My memory of that incident was that everyone felt much the same way, felt a bit worn out because it had been you know, worn out physically and emotionally and because even though you’re not tearful because you’re a professional, it’s quite difficult that sort of situation, but also everyone felt like they’d done a good job because they’d been in the room at the time and everything was done correctly.”

Sally’s reference to being professional and not being tearful is interesting and is an area that will be explored in more depth in section 5.3.6. She does identify the physical and emotional impact on herself and the team. She also infers that feeling everything had been done correctly provided a positive sense of assurance.

Nurses also spoke about a sense of turmoil on the ward. Jasmin’s (11) quote identifies the ‘frenetic’ environment when managing the situation including her

initial reaction to the incident. She also outlines how this was her first experience of such an incident and makes reference to the immediate psychological effect of not being able to stop thinking about the event. It was difficult to discern if this, in part, reflects her emotional response to what must have been a highly stressful situation.

As Jasmin (11) described the event she was visibly upset by the experience and was close to tears. This is in part reflected in the 'staccato' like construct of her account that may be evident in the quote.

“And it was a Saturday morning the ward was hectic, we had to refer him to PICU that morning, and he hasn’t had obs for half an hour, nearly 45 minutes can somebody check on him please and when someone opened the door he was just hanging. Arms folded and just found him. It was my first experience of this so somebody rushed in and went to bring him down and they were trying to resuscitate him. I can visualise it.I don’t know. There was no response at all. Everything that happened was like in turmoil, when these things happened, you know can’t stop thinking about it. ...”

John (03), unlike Jasmin (11) had seen other ‘suicides’. He described the difficult situation that he and his colleagues were involved in. John (03) seems to suggest that by having experienced a death before it was ‘less distressing’ or that he was somehow desensitised to the death. He also infers that if he was more involved in the physical aspects of the incident i.e. the resuscitation, it may have had a greater impact on him. Participants also used graphic language when describing the deaths. As can be seen in his quote John’s language is interesting as he seems to refer to the client in the third person.

“Nursing staff were clearly shook up because they had obviously responded once they’d found the service user and tried to resuscitate the service user.....I had experienced it before. I suppose it was less distressing that maybe others on the ward that hadn’t experienced it before, particularly people who had actually tried to resuscitate him; you know I think I would probably have reacted differently if I was in the thralls of trying to revive him. He’d passed by that point so he was lying on the floor with a sheet over him.

The police had obviously given instructions not to move him. So quite harrowing seeing a bit of blood from where they had cannulated him etc. Yes quite difficult.”

The experience of inpatient nurses and the management of the immediate clinical situation was the main area of difference between inpatient nurses and their peers in the community. The clinical situation and the physicality of trying to keep the patient alive were indelibly marked on the memories of the inpatient nurses. There did not seem to be any other discernable difference between any personal sense of responsibility between inpatient and community staff. The only area that seemed to differentiate between the effects of the death on inpatient staff and community staff was a belief from inpatient nurses about the response of their employer to the event. Their perception was that the organisation adopted a higher level of internal scrutiny to inpatient deaths. This suggests that whilst the individual nurse did not differentiate about the location of the death, the organisation did. This will be discussed in section 5.4.6

5.3.3 Reactions to hearing the news of the death – the need to understand

Apart from the differences described above a set of relatively uniform responses emerged from all nurses in relation to their initial response to the death irrespective of their place of work or type of role. A common experience from all nurses was the sense of shock, depersonalisation and disbelief when confirmation of the patients' death was received.

Mathew (07) gave a moving account of how he reacted to his client's death and how his initial reaction was almost a sense of paralysis. He became tearful when recalling how he felt when he heard his client had died. The recollection of the event was clearly upsetting for Mathew.

“It was a shock yes. Just a bit of numbness really..... but really just felt shocked and overwhelmed and just numb really.”

Nurses described how they felt it was hard to believe the client had died and this led to feeling the situation was ‘surreal’, somehow detached from what was happening around them. Sarah (09) shared her experience of arriving at her clients’ house to find that the police service and an ambulance crew were present. She described how she could see her clients’ body outside the house and how she desperately tried to find out what was happening.

“It was horrible. Horrible. It was a very odd experience because it was a bit surreal as I arrived and all the ambulance - I think they’d been there for about 20 minutes half an hour, and they were waiting for the coroner’s vehicle to come back - the coroner was there - and xxx was outside the house with a plastic sheet over her, the coroner’s office were kind of walking in and out of her house, and the ambulance men were standing around chatting, and I rushed over and kind of said what’s happened? What’s happened?”

Sarah’s (09) need to assimilate information to clarify what was happening was not uncommon. The nurse’s sense of shock was principally expressing a primary concern for the patient quickly followed by feelings of self-doubt and uncertainty about what they needed to do next.

Mathew (07) expressed his uncertainty within a context of feeling ‘overwhelmed’ by the gravity of the situation.

“really just felt shocked and overwhelmed and just numb really.”

John (03) shared Mathews feeling of uncertainty about what was happening, his response was to attend the scene immediately also to try and glean information on the way to the ward.

“First of all I suppose not knowing the detail, because I don’t think people can convey the detail in a panic over the phone to you until you actually get there, so the whole journey you’re thinking a number of things. Will they die, you know, what were the circumstances?”

One feature that appeared to be significantly different for community staff was the need for information on the circumstances of the death. Inpatient staff had a detailed knowledge of the circumstances of the death and any potential catalyst to the incident. However community staff did not have this level of detail and for some, a part of their immediate response was to try and establish details of the death.

Mathew (07) shared how one of the most difficult aspects was not knowing the circumstances of the death. Although he suspected the death was a suicide the uncertainty compounded feelings both for himself and others potentially involved;

“Probably one of the worst things was not knowing what had actually happened although I had a good idea that’s what it was, but just thinking about what had happened and thinking about the ramifications of that for the family, myself and the team and stuff like that.”

For some nurses there was also uncertainty about whether a death had occurred. This appeared to relate to the transient lifestyle of some of the service users or where information had been received from a source that was thought by the team to be unreliable. Lisa (06) spoke about how she tried to establish whether her client had died and how she felt at that time. She seems to describe how the not knowing and the uncertainty compounded the situation;

“So we then phoned around a few places, another hospital, and the police, and found that actually it was true. So that was all quite confusing for us for the first few hours after he’d phoned. Again, the same emotions, shock, crying, the client has died.”

This need to know appeared to be borne out of a concern for the client but also as part of the nurse managing their own anxiety about what had caused the death, as can be seen from James’ (05) quote;

“I just saw that person and they’re not there anymore and I remember worrying about what must have been going through his head to have actually done that.”

5.3.4. Reactions to hearing the news of the death – impact on staff

The need to understand the details about what happened seemed to lead some nurses to reflect on their own practice and specifically their last contact with the patient. This emerged as a desire to review the clinical case notes notably their last clinical entry and any relevant care and risk management plans. It was evident in all clinical environments but appeared to be expressed most strongly in the community when the nurses acted as the care coordinator. The role of the care coordinator has a clearly assigned level of responsibility over and above the role of a generic inpatient nurse. Janet (10) outlined her concern about whether she made an error, questioning her judgement and expressing a feeling of significant anxiety about what had happened and the subsequent events that would follow.

“Well you start to think what have I missed? Have I done something wrong? Are my case notes up to date? Is the risk assessment ok? Are they coming to get the file? So you go through that humanistic kind of grief for somebody that you’ve worked with and you know has died and then the panic sets in. Every time.”

Janet's (10) comments illustrate a sense of doubt regarding whether they could have prevented the event, a reaction echoed by many of her fellow participants. They frequently described a concern for whether their practice was satisfactory. A need to validate their practice was most apparent in their desire to review what they had written in the case notes. The need to revisit their records became a source of concern and frustration if they were unable to review their clinical notes. The management teams' response in seizing the notes as part of the immediate investigatory process seemed to exacerbate the nurse's feelings of anxiety. They felt less able to assure themselves that their clinical notes were satisfactory. James' (05) quote illustrates a sense of powerlessness regarding his control over what was happening.

"thinking what did I put in my notes, what did I say, you know were they ok? Was my paperwork up to date?No because the file's taken. So the file just disappears off because obviously people need to look through and they do all the root cause analysis and everything but I think it's a feeling of helplessness thereI felt shocked, definitely I felt shocked. I felt quite anxious as well in that natural "could I or should I" that kind of questioning."

A need to check and validate their own practice appeared significant in how nurses managed their anxiety following the news of the death. Helen (012) described how the fear and sadness for the death of the client moves to a more compelling sense of self-preservation. The comment below shows her concern for self also infers that she is worried or feels guilty that she may have contributed to the death.

"You just feel quite anxious because I suppose my immediate response is oh god did I do everything right, was there anymore we could have done, did we miss anything, was it our fault or was it my fault that this had happened and could I have done more."

Jo (15) echoed Helens sentiments and described a need to reassure her self that her practice was satisfactory and specifically if she had omitted anything important.

“Automatically you think have I done anything wrong? Have I noted everything? Did I miss anything you know?”

The reaction of nurses in relation to the circumstances of the death seemed relatively consistent irrespective of what service they worked in. The initial details of the death would suggest that some deaths were highly likely to be as a result of suicide. However other deaths, notably clients in drug and alcohol services, were more likely to be unexpected deaths probably related to the direct or indirect consequences of drug or alcohol misuse. These deaths may not be intended by the client and more likely to be accidental. Despite the clinical difference of the client group, nurses broadly reported sharing similar experiences when hearing about the death.

5.3.5. Summary

What emerges from the data regarding hearing the news of the death suggests that from a very early stage the nurses’ reactions are a mixture of genuine sadness and concern for the patient. These are often very quickly followed by a period of reflection on what the implications of the patient’s death may mean for their own practice.

The consistent factor throughout the interviews was nurses verbalising feelings of sadness and shock about the death of a client. They also described how they had exhibited physiological symptoms of shock and anxiety at the time of the death.

An initial reaction from the nurses regarding concerns about their practice was also raised. This will be described in more detail in section 5.5.

5.3.6 The consequences of the incident and the subsequent process of scrutiny.

After the initial response to the death participants outlined the medium to longer-term effects on both them and those around them. As each interview developed and the participants began to discuss in detail their case, many of the nurses expressed sadness and remorse about the death of their client. In behavioural terms this led to some nurses becoming tearful, expressing strong feelings of sadness and resulted in the need to establish whether they felt able to proceed with the interview. All participants continued with the interviews, albeit on three occasions I adopted a more tentative approach to questioning, as it appeared the participant was likely to become extremely distressed.

Thirteen nurses said that the only areas that triggered an emotional response was if, as in these interviews, they specifically thought of the case, or if a similar incident occurred which led them to reflect on the previous incident. This suggests that for most of the nurses involved in the study they would only recall their experiences when under specific circumstances. These experiences could be either a clinical situation similar to the initial incident or a forum where they were required to reflect on their experience.

Of the two remaining nurses, one had memories, which clearly linked to the anniversary of the serious incident. John (03) described how the anniversary of the event was now inextricably linked to the public holiday it shared, and therefore he felt it would be a constant reminder of the incident.

“It’s kind of a routine now and aren’t going to be the same.....Oh god no. Last year and the year before. I’m not saying I get distressed but you know you will always remember.....No it’s more of a passing thought I think. It’s kind of when people are having fun you can always remember that conversation you had with the

family oneand that wasn't very good for them and is never going to be the same."

Jasmin (11) stressed that despite the passage of time she still ruminated on the incident. Jasmin's quote below demonstrates how she continued to question her practice and whether this may have altered the outcome.

"Maybe I could have handled things differently. Maybe I should have asked staff to check and these things were all on my mind. But then others should have checked him but because this had happened I was questioning myself and I'm saying this to myself. And now I still think about it'."

Many of the participants described how the death and the aftermath of the incident was one of the most stressful and challenging experiences they had faced throughout their career. When describing how they felt about the incident a common language emerged utilising words such as, guilty, responsible, failure, shocked, upset and isolated. The notion of this event being a significant landmark in their career was relatively common. John (03), when reflecting on his experiences, exposed a view that was evident for many;

"I think it will influence me in my decision making and thinking forever I suppose."

Whilst only two of the nurses described longer-term effects, others described elements that seemed to influence how they responded to the incident. The factors that appeared to have made the event more difficult included;

- The nature of the relationship with the patient.
- The response from others, including the deceased family and carers.
- The response from their employers.

The factors that influenced these perspectives will be described in more depth from 5.3.8 onwards.

Some of the nurses described how they felt that there was a need to ‘be professional’ and not be seen to acknowledge the incident other than in the immediate post incident situation. It seemed important for some nurses to demonstrate that the death had not had any impact on their role as a nurse and that essentially it was ‘business as usual’. They recognised the need for emotional support and the impact the event had on them but tried to ameliorate this being apparent to others at work.

Sally’s (08) quote illustrates how she tried to cope with her feelings whilst masking this from her colleagues.

“So you try and put on this front that you’re ok”

The need to be coping was influenced by a perception that their peers were coping and they were alone in continuing to think about the incident.

Jasmin (11) described how she modelled her behaviour at work on her perception that colleagues were unaffected by the death. The quote below illustrates Jasmin’s belief that her peers were back to ‘normal’ which meant she did not discuss or acknowledge the effects of the death.

“trying to carry on as normal but the thing is you see all the other staff carrying on as normal and you think well I should do the same, do you know what I mean? ...Maybe, because no one talked about it. So I’m thinking it’s just me because my first experience. So I just carried on”

For some nurses it was important to be seen to be professional and portraying an image of coping was a fundamental part of their professionalism. Coping for these nurses implied that they would not demonstrate that the incident had any ongoing

effects on them and they were psychologically, physically and emotionally reconciled with the incident. Jacky (13) shared how she would adopt different behaviours at home and at work. She described how she would maintain a veneer at work that would not suggest she was having any ongoing concerns about the death of her patient. The reality was that outside of work she continued to think about the incident and within the confines of her home life expressed her feelings more openly.

“ I felt that I had a professional responsibility to my other clients when I was at work and also to my colleagues and that I wanted to be able to come in and be focused on what I was doing but when I got home, I could let that guard down and I could then be upset and emotional about it and think and reflect on it and I did actually do that in my own time really.”

The participants all described their initial response to the incident. Some of the responses suggested that the incident appeared to have a longer-term impact on them both personally and professionally. When the nurses were asked to reflect about the whole experience further insights were revealed about their emotional, cognitive and behavioural responses.

Most of the nurses interviewed were aware that following the death of their patient a period of scrutiny would commence. This scrutiny would involve a process examining the reason for the death and determining if anything may have mitigated the incident occurring. For most this would involve an internal inquiry from their employer as well as the external review by the coroners' court. This realisation of the commencement of a process of professional scrutiny and how the nurses reacted to this was broadly consistent for all participants. When participants understood this procedure would occur it was often felt to be anxiety provoking. Janet (10) articulated a common belief about the need for scrutiny;

“I think it’s necessary because of course for some people there may be elements of bad practice in services that do need to be recognised absolutely. It has to be done. It is helpful but it just doesn’t help your anxiety about the whole process.”

Janet’s (10) perspective regarding anxiety was common ground for nurses. Participants described a range of experiences that are symptomatic of a number of possible mental health conditions, including anxiety, adjustment disorders and a brief depressive reaction to events. For two of the nurses there was a suggestion that they may be experiencing a mental health problem more closely associated with a traumatic stress disorder. The commencement of the process seemed to be the catalyst for the manifestation of feelings of mild depression which for one nurse gave rise to discussing the need for anti-depressant medication with their GP.

The most striking feature of the incident and ongoing process was a consistent response regarding the impact on both the nurse’s behavioural and psychological responses across various aspects of their day-to-day and professional lives. The only overt area of inconsistency was in relation to the longevity of the phenomena, which varied from individual to individual with no obvious predetermined factors. It was therefore not possible to determine how long the relevant phenomena would occur for each nurse.

Despite the different responses of the nurses there were points in which participants described how their feelings or behaviours were heightened. These landmarks related to key points in the aftermath of the incident and the subsequent process of scrutiny, specifically areas such as, the organisations internal inquiry, the funeral of the deceased, meeting the family of the deceased and finally the coroners court.

A common experience for the nurses was the impact the incident had on their sleep. Jasmin (11) shared how bedtimes were difficult, as she would re-live the events of

the suicide. This included expressing concerns for others involved in the incident including the family.

“Oh my god, he killed himself, he hanged himself, my husband said you need to sit down you’re so upset, and it is very upsetting when it happens and also ... he had children as well but it just came back to me in flashbacks every night. The incident. You think about family, the doctors, just...Just every day, but when I go to bed I couldn’t stop visualising what happened.”

Janet (10) shared her thoughts when she awoke during the night. She outlined how she tried to deal with her anxieties about the case at work but how they would overspill into her home life;

“it’s mainly contained at work, though you know sometimes when you’re lying in bed and you wake up in the middle of the night it’s one of the things that pops into your head. ...Yes, it does. As I say, I’ve got a pending coroner’s court from a death over the Christmas holiday and when you wake up at 3 in the morning that is one of the things that you’re thinking, you know. You still go through that have I missed something, should I have known something; you know what could I have done differently?”

James (05) discussed how the anxiety about the coroners hearing was disturbing his sleep and becoming the first thing he would think of when waking.

“Well, I think my sleep was not so good but it is at night that you think about things and you’re worse aren’t you when it’s quiet and dark but I think in the mornings as well when you wake up and kind of think about it...”

James further outlines how his anxiety manifested in a physical response over and above his sleep disturbance;

“....It did make me feel really anxious because you hear the word court and quite rightly so you feel like oh no I’m accused of something... I was feeling really sick and I had a headache.”

James’ (05) account also identifies his concern of feeling that he is ‘accused’ of something. Jacky (13) shared how, as the inquest approached, the more intrusive and regular the experiences would occur and how she tried to develop strategies for dealing with her anxiety. Jacky’s (13) experience was similar to James (05) as her concerns related to what the outcome would be at the coroner’s court. Her quote below shows the impact on her sleep, early wakening and the constant rumination of the pending inquiry.

“Anxious, very anxious about it....Yes probably I was just thinking about it more at home than at work..... I was waking up early worrying about it and sit there thinking about it. I think I generally would sleep but sometimes wake up early and not go back to sleep because I was dwelling on it and thinking about what might happen. That was a difficult time and I remember being quite preoccupied with it and wanting to get it out of the way before Christmas and it just felt like it was going on quite a long time and just wanting to get it out of the way really. Yes I went for a lot of long walks on summer evenings and I used to think about it then and get quite emotional about it. I think I was probably a bit more preoccupied at home and things and it was on my mind a lot especially coming up to the inquest and kind of a few times in between that....”

The physical manifestations of symptoms of anxiety were apparent in most of the participants when they reflected on their experiences. Sally (08) described the most common phenomena;

“It was horrible. You couldn’t eat, you felt sick, stomach was in knots.”

As previously described some of the participants became upset when they discussed their experiences of the incident. John (03) when describing how he felt at the time of the events started to re-experience some of the feelings of anxiety.

“It was an awful sick feeling you would get if you were going to be doing something which you dread, whether it’s an exam, if something horrible is happening at home, if your children get hurt. It’s that horrible feeling in your gut when you feel awful and you feel paralysed with it I suppose. I’m feeling it now.”

Michael (02) described how he continued to worry about the ongoing case particularly as the hearing drew closer. He expresses frustration about the case transgressing into his personal life,

“Probably I couldn’t maybe switch off so easily. I would try and cover it and feel that I had done everything to the best of my capabilities so that when I did get home I don’t have to worry. But because of this and because it was looming, I think it was about 4 months, it did play on my mind. I wouldn’t say it kept me awake, but it was an extra thing that I didn’t need to be worrying about.”

When reflecting on the effects on their relationships at home, either with their family or friends, participants described various ways it impacted.

Jacky’s (13) experience was that she found her concern about the incident was more prevalent at home than at work.

“Anxious, very anxious about it...Yes probably I was just thinking about it more at home than at work.”

For some nurses their experience included the positive effects of support offered by their family, perceived by some, as a vital component in maintaining their own wellbeing and reducing the associated stress and anxiety.

John (03) shared how important his wife was in offering protection from inquiring friends and family in the immediate aftermath of the incident when he was late attending an important family social occasion.

“And my wife was very aware because she knew and she was in a way protecting me. She was making sure that people didn’t approach too much, stayed with me so that I wasn’t on my own and asking why I was late. In a protective mode and my children that were quite young were asking where have you been dad, she was saying that he’s been busy at work, so in a way she kind of provided a protective element I suppose to that.”

John then outlines how difficult he found trying to hide his true feelings from his friends and the techniques he chose to avoid the need to discuss the detail for his lateness.

“It was awkward. I couldn’t not turn up but you know, I had neighbours saying why are you late? I had to hide my feelings and distress and couldn’t get into the party spirit for obvious reasons. Trying to mask it and I kind of had to lie rather than say what I had experienced, you would have had more questions and it would have just added to the awkwardness.”

Barbara (01) shared how she tried to keep her work and home life separate but recognises the importance of family support when work becomes difficult.

“ Oh outside of work? No I contain it well actually. I do get quite stressed, yes I suppose I do, but I very much try to keep work as work and home as home. I am

saying it doesn't always work that way but I have a very good family and in a very lucky position really. Not that you'd go home and say everything about what happens at work because I just don't do that, but they do know when I'm a bit down and they just assume that work's bad or something and they don't ask, they are just there. I think I am very lucky with that to be honest."

Mathew (07) emphasised how beneficial friends were in providing him support and seems clear those around him were aware how he was feeling.

"Yes, probably, I mean there are some friends who I knew would understand what I was going through and I kind of opened up to them, that was highly useful, but my family were in and I lived on my own here so no family to kind of confide anything really, but certainly some friends were useful. I'm almost certain people noticed at work and in my personal life as well."

Mathews' (07) comments are particularly interesting as he infers that he shares his experiences with those who would 'understand'. The need for people to understand the experience of the nurses seemed to be an important factor in whether they would choose to disclose their experiences. Some said they would not discuss the incident with their immediate families as they felt their families would not understand what they were experiencing. Lisa (06) provided her perspective on why, whilst she felt her family probably recognised her distress, she found it difficult to discuss her work.

"Yes I think it does to a certain degree. Definitely at first it's on your mind constantly. I guess they would have noticed that I was upset but it's quite difficult to talk to you family anyway about work stuff you know they don't kind of understand the client group."

Some nurses described how they would deliberately mask their feelings to family and friends as they did not want work to intrude at home.

5.3.7. Summary

Participants articulated a range of relatively common experiences that arose from both the initial incident and the subsequent period of scrutiny. These ‘common experiences’ included a variety of psychological, emotional and behavioural responses to these adverse events. These experiences transgressed both professional and, for many, their personal lives although the level of intensity and intrusion varied from person to person. Nurses would make definite choices about whom they would share their experiences with; some suggesting that the persons they disclose to needed to have some insight into their work to truly understand their experiences.

5.3.8 Relationship with the service user

A key clinical skill for mental health nurses is the ability to develop a therapeutic alliance with their clients to facilitate their mental health recovery. The nurses who expressed that they had a closer emotional connectivity and therapeutic relationship with the patient described how the death had a greater personal impact on them. This was perhaps most evident from nurses working in drug and alcohol services who tended to have experienced multiple deaths due to the nature of the high risks behaviours exhibited in their clients. Barbara (01) described how she had experienced the deaths of several patients whilst working for over twelve years in substance misuse services. She outlined how the relationship with her client could determine her response to the death. For those with whom she had a long term relationship with this evoked real sadness, for others she felt anger given the circumstances of their death;

“Absolutely. I mean, with him who I was describing, because I had worked with him so long and because he was such a loveable rogue, his death has probably been one of the worst I have experienced really and it’s because he was such a character and because I felt that I’d had such a good relationship with him So for 10 years or 8 years, what ever it was, I had a really good relationship with him so that was huge. I knew that at some point, because of the way he carried on, he wouldn’t see 50 or 55, but to be told, having seen him 2 days earlier when I thought he looked pretty ill, I didn’t feel that he was going to die and then be told by the pharmacy that he was dead.”

Below Barbara (01) shares why she felt it was different with other deaths and how the nature of her relationship is important

“So that was very different to recent clients who I had worked with for about a year. so when my recent chappie died, it was an impact and very tragic the way it happened, but it didn’t have the same impact because I didn’t have the same relationship with him as I did with the other client really. I do think the relationship affects it. It’s all very tragic anyway. I think the girl that’s recently died, I’d worked with her for a very long time and she died in hospital. She was in her 30’s and that was tragic and I was more angry about that. I was angry with the family and the whole situation that she had found herself in. I felt very sad that she died on her own, you know those sort of things and she hadn’t had a life so I felt very angry about all of that.”

Other nurses expressed the view that they believed they would have felt worse if they had known the client for longer. Michael (02) shared how he experienced the death of a client through suicide only nine months after he qualified as a nurse. Whilst the experience had clearly affected Michael (02), when considering how he felt about the death he said;

“I think it would have affected me more if I’d had a deeper understanding and I’d had a longer relationship with him.”

Sarah (09) shared how the length of the relationship was not the only determining factor of the impact of the death, but also, whether she liked the client on a personal level. She illustrates how the emotional connection with the client may be an important determinant in how the nurses feel about the death.

“I think it does yes, because I did as a human being I liked her and I liked her children and I think if I didn’t, as with other service users who I don’t like, I don’t think I would have been as upset. I might felt as strongly for different reasons but I don’t think I would have been as emotionally upset about the whole thing. No.”

Nurses also reflected on other factors that had brought them emotionally closer to the patient. One of the factors referred to on a number of occasions was the deceased being much younger than the nurse. Some nurses spoke of the patient being the same age group as their own children and one expressed the view that ,on reflection, she had taken on a ‘ parenting role’.

Some of the participants also expressed that this loss of someone close, albeit through a professional relationship, would go unrecognised by many. Janet (010) describes how she felt a need for those around her to offer ‘comfort’ but alludes to wanting others to also ‘understand’ and ‘empathise’ with her experience.

“you go from being upset as if a friend had died, you know you kind of want to be comforted, you want to talk about it and you want someone to you know empathise and sympathise with what you’re going through.”

Some also stated managers needed to have a better understanding on this point. They felt that managers failed to recognise that if you had developed a close working relationship with a client you cannot just cease to have feelings for the person particularly in the often tragic circumstances that the surrounded the incidents. John (03) suggests that more could be done to recognise the impact on staff, the personal consequences of working with someone who has died, and how it affects the individual involved.

“I think the biggest issue for me is more around getting people to realising the kind of impact of a human tragedy like this. Different veneers, you know, community team will see somebody every week, might be very different from someone who is only going to see them once a month in the clinic. Relationships are more distant but there are relationships sometimes that can really affect staff I think.”

The relationship with the patient appears to be a significant issue in how the nurses respond to the death. Some nurses working in substance misuse differentiated between whether their client dies unexpectedly from drug and alcohol issues or suicide, particularly making the point of how and why the client dies. They seemed able to rationalise the cause of death more readily if it was due to lifestyle choice. This still had an emotional impact on them, and many expressed the futility of the loss of life. Frances (04) outlines her perspective on death of a client;

“It depends I think. For some people that I obviously don’t know I can feel fairly detached about it and having 20 years experience of working in substance misuse I think you probably do develop a kind of I’m not that surprised feeling but when it’s someone that I have worked with in the past or I did know quite well or I knew an awful lot about them, then it is quite sad, well of course it’s sad and you think well what a waste of a life.”

Helen (12) adopts a similar fatalistic perspective to Frances and appears to differentiate between clients who seem to have more control or choice over their destiny. Helen also infers that her own sense of responsibility or accountability is different between the two differing client groups.

“I guess you think well actually that person knows all of these risks, he’s very aware and he’s ambivalent about that and that’s very sad that you can’t do anymore than that and you have to accept that’s their choice, they’re an adult and they are making that choice whereas with somebody like the girl I talked about it’s different because she’d had mental health problems and accountability is different because of her own incompetence at that point and that her mental health affected her decision making.”

Many of the participants reflected on the relationship they had with the service user. This period of reflection engendered a range of responses from them. One of the predominant emotional responses from nurses was anger. They also questioned their own clinical practice and judgement in whether they really knew the patient. They felt a need to understand why the patient had not told them they were considering suicide or that their lifestyle might have become more chaotic.

Janet (10) acknowledges feeling responsible and questions whether her relationship with the client was as honest as she believed. She appears to question her own judgement about whether she should have known that this would occur and finally expresses her frustration and possible resentment that the client death has consequences for her;

“You feel responsible because you feel that you’ve had a relationship with these clients for a long period of time and you feel that you should have the sort of relationship where there’s honesty and the feeling that the client has been able to divulge whatever they’re doing in a safe and therapeuticYou feel that even if they didn’t disclose it you would notice something..... You do feel that you should

have known. You should have known..... It's that feeling that part of you also thinks how can you do this to me? There is that you know."

Janet's (10) feelings are similar to Sarah (09) who wondered if the client had chosen this method of suicide as a way of punishing Sarah. She also illustrates the anger that many nurses experience following an unexpected death or suicide.

"Was she doing it because I was coming round and she did have certain personality traits so was it a kind of punishment because I had worked with her before and she did keep saying to me, I told you this would happen and I did wonder whether there was some kind of "I told you this would happen and it did happen" so I felt really angry but not quite sure who I felt angry with. At the time I was angry with mental health services but I'm not sure if I really was, and if I was angry with myself as if I was blaming myself or that I was angry with her for killing herself."

Participants also described how they felt a heightened sense of responsibility and self blame for the death. They outlined that, because of their therapeutic relationship, they should have been able to detect that the client may have been likely to behave this way. Barbara (01) illustrates how she questions her beliefs about the validity of the relationship and whether her judgement was wrong. The possibility that the relationship with the client may not have been as close as she perceived challenged Barbara (01) and others with similar experiences.

"I thought we sort of got to this point for several years where he was self monitoring and we've got a good relationship, so you question your relationship as well. Was it as good as you thought it was, was it not and my perception was completely wrong, completely skewed? That was quite hard in a different way, yes."

When discussing this in detail the nurses accepted that this perspective was not realistic. However emotionally they still felt they had a heightened sense of

responsibility and therefore this sense of self-blame was hard to eradicate as Janet (10) illustrates below;

“I mean with the client that was found overdosed and deceased in the stairwell, I felt right up until the coroner’s date that I should have been able to help him. I suppose I should have been there that if he was having problems he could have come and spoke to me about them”

5.3.9. Summary

The relationship with the service user influenced some of the emotional responses from the nurses. All nurses expressed a level of sadness and sympathy about the death; however where the nurse had developed a stronger bond with the client this appeared to be an indicator for a more profound emotional impact on the nurse. Nurses expressed a range of feelings about the loss of the client and specifically the circumstances of the client’s demise. This would for some, include feelings of anger, a sense of betrayal and frustration that, despite their belief that they were close, the client had still taken their own life. Some of the nurses would also question their judgement regarding their perceived relationship with the client and try to understand why they had not known or why the client did not say about their change in circumstances. Finally some nurses shared how there could be greater recognition from those they work with concerning the personal effects on them and eluded that they received greater support from those who could ‘understand’ or ‘empathise’ with their experiences.

5.3.10 Relationship with the family of the deceased

The close involvement of families and carers of service users has, for many years, been seen as an integral part of providing high quality care in mental health services. The participants in this study affirmed that the relationship with carers and families after the unexpected death or suicide frequently became a source of considerable stress and anxiety.

The first significant finding was how the families became aware of the death and the role of the nurse in this process. Community staff generally heard about the death from the families or other agencies such as general practitioners or the police service. Where the death had occurred in an inpatient setting this required the nurses to contact the family and advise them of the death of their family member. Staff who had worked in both community and inpatient settings acknowledged that it was a very different experience hearing the news of the death rather than having to take on the role of the 'news breaker'. Those nurses who found themselves in the latter situation said that as inpatient deaths were relatively rare they had not had to do this before and therefore had never received any training in 'breaking bad news'. They felt that the situation was also more difficult as there was a greater expectation that their patients 'would be safe' as they were being cared for in a place of safety i.e. an inpatient ward. Nurses who found they had to break the news of the death described this as incredibly stressful and anxiety provoking. They described how their stress manifested from the awfulness and magnitude of the situation, not knowing how the family would react to the news and for some a lack of real understanding at this early stage about what had led to the death. They described how the families of the deceased would want details of the death so they could understand and make sense of what had happened. This understandable need to know from the family would make the situation more difficult for the nurse as they were not able to provide detailed answers.

John (03) provided a candid insight into the enormity of advising a family that their child had committed suicide. John (03) started his account by describing his lack of experience in breaking this type of news

“Oh yes it was heart wrenching. That’s something I had never done before. Not being the first clinician or health person from a health point of view, talking to the family about it. I think in the community it’s different because you often find out that way, so yes that was difficult.....”

He then outlines how he endeavours to deal with the emotional reaction of the family and provide them with some information about the circumstances of the incident.

“It was the mother and she was in absolute shock and stress. When you’ve recently seen them the day before, it was more questions like we only saw him yesterday what’s happened? They weren’t really in the right mind to have an ongoing conversation about it. It was more about me explaining that it was terrible that this has happened and we tried our best but couldn’t resuscitate him and offered for them to come up, support them you know.”

John (03) then reiterates his lack of experience and verbalises how he felt a sense of ‘panic’. He suggested that this was borne out of uncertainty about not knowing what the family would require from him and also the unpredictability of their reaction. Part of his own uncertainty appears to emanate from not knowing how much detail he can disclose about the death. All of these variables contribute to a very stressful experience, with a palpable sense of relief from John, once the conversation had concluded.

“ So it was very difficult....Mostly panic, what do I say? Because that part I had not actually experienced before. Part of me was in a blind panic because I didn’t know what they wanted to know and what they were going to ask. Whether I could share

answers to some of their questions. You know it was unknown territory to me which caused me a lot of anxiety. Afterwards it was kind of relief that our conversation was over. It was awful. That was probably one of the worst parts of it.”

Barbara (01) affirms the difficulty of these types of conversations and how ultimately you may not be able to allay all the families concerns.

“So when the family are asking you questions, they are clearly looking for some closure for themselves to try and understand their son/daughter or whatever, how did it come to this? Sometimes I don’t think that we can give them what they want really.”

Whilst community staff did not have this specific experience they did outline how meeting with the family was a source of stress and anxiety. Nurses expressed concern that the families would seek to blame them for the death of their loved ones. In some cases, particularly if they did not know the family, they would be fearful that the family might be hostile or aggressive towards them. This point was particularly evident as a source of anxiety for nurses at the coroners hearing. The response from the family appears to take on an importance in how the nurses dealt with the death, the subsequent inquiry process and how they psychologically responded to the feelings associated with the incident.

Despite anxieties about the uncertainty of response from the family a number of the participants had chosen to attend the funeral. Nurses described that attending the funeral was an important part of acknowledging their care and concern for the client. They also outlined how this was a way of saying goodbye. Participants described the funeral as ‘emotionally draining’ and shared how they became tearful and upset. They described how an emotional release came immediately after the funeral. They inferred a need to try and maintain an illusion of professionalism and only being able to show their real feelings when not in view of the public or family members. James

(05) described a common feeling regarding how the tension of the day was heightened by the uncertainty of whether family members may seek to blame staff or the Trust for the death of their loved one.

“Yeah, I felt quite awkward and you want to go and pay your respects and it’s important to but at the same time you don’t know what people think about you and the service you represent. You don’t know if people kind of lay blame at your door, you know that kind of thing, so it was OK I guess. I was a bit tearful afterwards to be honest, myself and the care co-ordinator got in the car, but I feel that was probably the tension of not knowing and you don’t know do you and it’s hard if you don’t know the family very well.”

Nurses described how some families made a point of thanking them for their help in caring for the deceased. In some circumstances this expression of thanks also included statements that the nurse could not have done more and could not have prevented the death. These statements were particularly powerful in helping the nurse reconcile the loss of the client. Some of the nurses said that this positive response from the family was unexpected but hugely important in helping them in their sense of both loss and anxieties they had about their own practice. Lisa’s (00) quote illustrates this point.

“Oh it was such a relief and that made me feel so much better about everything, you know, them just thanking me for my support and then similarly in the second time I went, because the first one I didn’t know the family, but the second time I did know the family as I had met them when I went round to the house, and they were even nicer to me, you know thanking me for the support over the years, so in both cases the court cases were really similar with the same feelings, but you still are very anxious about what the second family are going to say, but then they were really nice.”

Sarah (09) also spoke about the positive nature of her meeting with the deceased's family. One of Sarah's concerns was how her client's children were coping with the death of a parent.

".... It was actually very positive for me because she was doing incredibly well. She had been at school,They were doing generally ok and the little boy was flourishing apparently living with his..... and doing extremely well at school although he spoke about..... he didn't appear to be distressed about it. So for me it was a very positive meeting because I could feel better about all the children and I suppose I could then let that little bit go because I didn't have to worry about them because they all seemed to be doing well."

Sarah's (09) comments suggest that seeing the family were coping and continuing with their lives enabled her to reconcile her own feelings.

A positive response from families was not the experience of all participants. When the families expressed anger or concern participants found this extremely difficult and anxiety provoking. This was most evident at the coroners' court where participants knew that the family might ask challenging questions. Most staff were aware that the family would be present at court; for those who were unaware, it appeared to heighten their anxiety as they had no time to prepare for how the family may react to them. Some nurses advised that, after they had given evidence and portrayed the complexity of the clients needs, the family appeared more positive towards them. In a few cases nurses and their respective organisations took a more proactive approach to communicating with families and would share any internal review findings with the family prior to the coroners hearing. When this happened, or the family accepted the views of the evidence given at court, the outcome appeared much more conciliatory.

Some nurses expressed concern over their lack of knowledge of court proceedings. Specifically their uncertainty as to whether they were able to approach the family at court and express their condolences. In the absence of any obvious dialogue with the family, or pre court preparation concerning the family the situation appeared to lead to a more adverse outcome for the nurse. Janet (10) described how she felt ill prepared for court despite knowing that the family would be hostile. This experience had a significant impact on how she felt about herself professionally particularly when the family challenged her so vociferously.

“Horrible; hideous. I think the first one I went to I knew there was a lot of feelings of animosity from the family.....Towards the service, so I wasn’t looking forward to that....Yes and it was horrible as anticipated. Just that the family and the partner were shouting things like you know, you should have done better, you knew he was ill, you didn’t do this and you didn’t do that. ...It made me feel really rubbish you know.”

Martin (14) further illustrates how anxiety provoking the court can be and how the anger of the family towards the organisation can feel directed at the nurses giving evidence.

“The sight of husband, two sons, their wives and I think the daughter all dressed in black sitting along one side in front of you was very imposing, very anxiety provoking it became anxiety provoking because it became quite clear almost from the outset that they felt very angry towards the Trust and they were apportioning all blame on the Trust and as the face of the Trust I was getting the steely looks.”

Participants described how their uncertain role, combined with the absence of a ‘plan’ of how to manage any potential complaints from the family, exacerbated the anxiety associated with attending the court. This was further evident for those nurses

who had not been made aware that the family would be present, the immediate realisation of this, and the absence of a 'strategy' to manage the situation heightened the stressful nature of their experience.

5.3.11 Summary

The relationship with the family is an important factor in the overall experience of the nurse and how they cope with the death of the client. Participants described how this could include, for inpatient staff, the difficult role of breaking the news of the death to family members. Participants in this study said they had received no training for this aspect of their role.

Many nurses felt that attending the funeral was important for them in 'saying goodbye' to the patient. The nurses felt that attending was important despite the uncertainty of how the families would respond to their presence. They also described how attending the funeral, whilst emotionally exhausting, was generally cathartic.

Positive feedback from the family was seen by the nurse as a major aspect in helping them recover from the trauma of the incident and subsequent events. The affirmation from the relatives appeared to be an important factor in reduction of stress experienced by the nurses. The reverse appeared true when nurses had been exposed to families who were more hostile or aggressive. This appeared to compound how the nurses felt and for some increased a sense of feeling guilty or blamed. This sense of blame was apparent even when the family were directing their anger towards the organisation rather than the individual. As the representative of the organisation, nurses would feel a 'de facto' responsibility for the case.

5.4 Section 2 - Factors that make nurses either, more, or less susceptible to experiencing an adverse psychological response

5.4.1 Introduction and synopsis

This section will outline the experiences of participants in relation to what positively or adversely affected their response to the death of a client. It is apparent that a number of areas are particularly important when considering what will mitigate or impede the likelihood of a nurse having an adverse psychological response. Participants placed great emphasis on the need for a supportive team environment combined with a personalised approach from credible management. The timing of the support from management was also felt to be important particularly in responding to individual needs rather than a 'blanket' implementation of well meaning, but sometimes poorly implemented policies. As part of the personalised approach nurse managers would need to consider how they can overcome the mistrust espoused by some of the participants. Equally it was felt to be important that support for senior nurses should form a greater part of the organisations response to serious incidents.

Participants described psychological strategies that afforded them a level of protection from the stressors associated with the aftermath of the death. The most important element appeared to be self and then organisational validation that they could not have done any more to prevent the client death. This links closely to the process of professional scrutiny and feelings of blame that are also associated with factors that ameliorate adverse responses. An interesting point was the nurses' perception of blame and fear of disciplinary actions was disproportionate to their actual experience. Concern for their professional registration with their governing body was also a consistent area that emerged but again none of the nurses involved in the study had actually either been disciplined or referred to the NMC. Despite these realities the perceptions evoked incredibly strong negative feelings which possibly,

could have been negated by a more timely and informed response from their employers. Finally, in finding closure to the incident, affirmation from the coroner as well as Trust senior management were frequently described as important elements of enabling a return to professional and personal normality.

The nurses identified a number of consistent areas that emerged from the interviews. The areas identified through analysis and described in detail later are;

- Supportive factors protecting them from a adverse psychological response
- How they psychologically responded to the incident
- The effects of perceived blame, professional scrutiny and fears for their nursing registration.

5.4.2 Supportive Factors

All participants described the various psychological support mechanisms that were available to help them cope with the incident and subsequent inquiry process. These fell into two subcategories categories; formal support, offered through the implementation of their employers' policies and informal support networks notably their teams or peers.

An overwhelming view from the participants was that a close and supportive team environment was a significant mitigating factor in helping them respond more positively to the stress and anxiety provoked by the incident and the ongoing process of scrutiny. This 'support' was described as an opportunity for the nurses to speak openly about how they were feeling about the whole situation. Importantly nurses described that this process of speaking openly was about not fearing criticism or reprisal for their actions. This supportive culture was seen as an ongoing factor in helping participants cope with the situation from the onset of the incident through to the coroners hearing.

Sally's (08) quote illustrates how having her team around her and the mutual sharing of experiences was a source of support;

“What helped me cope was being there with colleagues that were feeling the same if somewhat to different degrees of tensions and stresses. I think sharing that experience with other people was helpful and having that support of each other. It was very much a supportive group of people that went.”

The perception of the response from management was more varied. Many staff said that their immediate line manager (the team manager, ward manager) was very supportive. This was particularly evident when the nurses described the beneficial impact of a consistent senior person supporting them through to the coroners hearing. This was felt to be even more helpful if the manager had also experienced similar events, as participants felt there was a greater sense of understanding and alignment of feelings.

Jo (15) spoke about the support she received from her manager;

“I know his experience is over 40 years in the NHS. His focus in his career has been very much from the worker's point of view he's been a union rep so understood all of the corporate side of the NHS but also the worker side so he'd got lots of empathy, worked in forensics for some time as well so knew all the details.

It sounded like it was helpful because he was interested in you as well

Very interested and he had a wealth of experience. Yes. Very good”

This is suggestive that immediate line managers with similar experiences and a degree of clinical credibility seemed to be an important factor in positively supporting the nurse. Nurses like Jo, described this felt particularly supportive if they

felt the manager was genuinely interested in their situation. Lisa (06) suggests that her management team expressed their interest in her by regularly checking to see how she was feeling;

“I think I am really fortunate working here because we have got a really supportive management team, like I’ve said already I’ve got lots of supportive friends that work here, but actually the management are really supportive and they regularly check how you are feeling about anything, about any anxieties about it. So I think that helped a lot.”

Those staff who stated that their immediate line manager was unhelpful seemed to describe greater feelings of professional isolation which exacerbated their ability to manage the anxieties associated with the incident and subsequent inquiries.

Senior management were sometimes perceived to be distant and uncaring about the individual nurses. Some nurses spoke of only having contact with managers when something is perceived to have gone wrong. John (03) gave an account of when a very senior manager met with him and implied that this type of incident could not happen again. John’s (03) interpretation was that this was essentially warning him that a further incident would be detrimental to his career.

“ I can say that I had knock on my door, hello how are you, are very worried about this and it can’t happen again. That was probably one of the most difficult things to know that were very worried I knew they were very worried

Do you think that was appropriate?

..... being they are terribly influential and powerful people and you’ve got to kind of sit up and smell the coffee really.”

John's (03) last comment further affirms that he is very much aware about the potential implication on his career if a repeat incident occurred and what this might mean for his employment.

Some nurses welcomed the support made available through corporate governance functions, notably the opportunity for individual or team debriefing. Others suggested that the timing of the support was often poor it would either come too soon or too late. They described it could they either felt too emotionally raw to discuss their feeling or paradoxically if too late it was like 'opening old wounds'. It was felt that the corporate support was not sufficiently personalised to either the individual or the team; some nurses described how it felt like a 'blanket' approach and they would have wished for a more tailored and individualised approach to meeting their needs. When the corporate support was unknown to the recipient it could compound their feelings and heighten their anxiety. They described that, at a period when the felt under intense scrutiny, they where uncertain if they could trust the person sent to support them. Jacky (13) describes her experience below. Jacky commences by outlining how she had not shared how she was feeling and infers that she was willing to do this with the psychologist from her team.

"I didn't tell anyone that's how I was feeling and to be honest, a few months after the event, we were offered some kind of grief clinical supervision with somebody coming over. Now our psychologist had offered to do this kind of work with the team or individually and he'd always said either formally or informally he could do some kind of supervision and we were all kind of quite keen for that to happen but as it happened it was kind of taken out of our hands as a team and it was kind of implied that we needed someone, a psychiatrist to come over who didn't know anyone."

Jacky (13) then describes how the decision was taken and implies a sense of powerlessness in determining what type of support she might benefit from. She then details how she is reluctant to disclose her feelings due to her concerns about how

her disclosures may be heard by the organisation and that it could be included in her personal records.

“They felt it would be better if someone from outside of the team came over to do the supervision so it was somebody none of us knew, he wanted to come over and do a group clinical supervision and I can’t even remember if we had it.....I don’t know, if it’s somebody that is directly involved with the Trust you feel that you have to be careful what you say, that there’s all the political connotations. I don’t know but I just imagine that there’s just my interpretation of it maybe but it’s almost as if there’s certain ways you should or shouldn’t be dealing with stuff and that might be best kept to yourself rather than telling the Trust how you’re dealing with it because that will probably be put on your personal records somewhere and it feels like that I don’t really want that on my record.”

A few nurses verbalised how they felt senior managers were primarily concerned about protecting the reputation of the Trust. This was informed by a perception that senior managers did not contact them personally to see how they were responding to the incident. This appeared to be particularly important as the coroners hearing approached. An important element in ameliorating a nurse experiencing adverse psychological effects was a view from their employers that they were not to blame for the incident. Nurses re-emphasised the need for a more personalised approach and that reassurances from senior management would have been extremely beneficial.

Janet (10), clinical nurse specialist commented;

“I suppose what would be helpful is when they take the files away or they look at the coroner’s report, if someone could then speak to you and say actually I’ve looked through your paper notes I’ve looked through the care notes and the coroner’s

report and I don't think you could have done anything different, you know, rather than wait for the coroner's."

Barbara (01) concurred with this view with an acknowledgement that scrutiny from managers was not always inappropriate and how recognition for staff from Directors would be very positive;

"We hear when it goes horribly wrong, boy are we hauled over the coals for that, and quite rightly so in some cases, but when it goes well, you think that just somebody to come down at Director level to say yes, you're doing OK."

Senior nurses working in management positions, also remarked that they were affected by the death. They felt their needs would often be overlooked due to a perception that somehow they were unaffected by the death.

John (03), a nurse with twenty years experience in mental health nursing outlined how he felt senior nurses may be perceived to be untouched by the death of a patient and the immediate aftermath;

"I think people see managers as fairly distant so they shouldn't be affected, but you should be taking on its merits and in my case I've got responsibility so I need support as well. But the input I had with the family and the involvement I had, you know, I don't think you can understand how distressing that can be until you've done it and I didn't understand how distressing it was going to be until you're sat in a room with a mother grieving, crying you know,"

The importance of support became particularly important in the preparation nurses received for the coroners hearing. Most nurses found it very helpful to have an opportunity to meet with managers and, when relevant, the Trust solicitors to discuss the cases. A few nurses said that these meetings heightened their anxiety but most found them beneficial. They described how it was important for these meetings to

take place well in advance of the hearings as when they were not given sufficient notice or preparation time it significantly increased their anxiety. Some of the nurses felt these meetings were helpful as a particular concern was their belief that whilst giving evidence someone would try and 'catch them out'. The opportunity to rehearse particular lines of inquiry was thought to be helpful. This included both from a technical perspective regarding 'knowing the case' but also, for some, the opportunity to assess how they might react emotionally to the questions they may be asked. Nurses also spoke about the positive benefits of a solicitor being present in court and how this reduced their anxieties about the case.

Some nurses outlined that they were not sure what support could have made the experience any less difficult or stress provoking. They described that the stress they felt throughout the whole process only abated when the coroner validated their professional practice by saying nothing more could have been done for the client. Hearing this affirmation from the coroner appeared to be the most influential aspect of preventing any ongoing adverse psychological effects on staff. Michael (02) outlined how he was constantly worried and found it hard to move on until he heard from the coroner.

"I think it wasn't really until the coroner's court at the end when he's said that we'd done everything, then that was my closure because obviously that's what was worrying me the whole time."

Staff verbalised how they could not fully accept from their manager that they had been clinically faultless until the coroner confirmed this view. Once the coroner case had concluded, for most, this brought complete closure on the case. Janet (010) shared a common view about how important the coroner's comments are in feeling reassured that you could not have done more for the client;

“it seems the coroner’s court is a feeling of closure. It certainly has been for me in the four experiences I’ve had, because at that point often you are reassured that it’s been a positive outcome and so the coroner has reassured you that no you couldn’t have done anything and this was death by misadventure, you know and to me you feel phew.”

5.4.3. Summary

Participants described a number of areas that provided a greater or lesser degree of feeling supported from the initial incident, the process of scrutiny and ultimately the coroners hearing. A close supportive team environment, combined with credible supportive management appeared to proffer the best outcome for the nurses. This was particularly evident when combined with a timely and relevant psychological debriefing. Some participants’ expressed some unease and suspicion about the intent of corporate support. This suspicion would impede the transparency of how they really felt as they described an uncertainty about whether information disclosed may not be kept confidential. These nurses stated that they wished they could have a greater level of control over the type of support they received.

A clear and consistent approach to preparing for the process of scrutiny was also found to be beneficial. Some senior nurses felt that, because they worked in a more managerial position, their need for support was sometimes overlooked with a tacit assumption that they would just ‘get on with the job’. These senior nurses felt that this was insufficient and employers for all levels of nursing staff should have a greater regard. Nurses working at all levels said supportive contact from Directors would be beneficial as a final affirmation the Trust both supported them and accepted their practice was not at fault.

Finally, nurses also expressed a view that hearing the coroner affirm that they could not have done more for the client, nor predict or prevent the incident was an extremely important aspect of their ability to find personal and professional closure.

5.4.4. Psychological preparedness

The nurses shared what made them less likely to experience any adverse effects. Specifically some outlined a psychological defence process that enabled them to make sense of what had happened to the client and what was now happening to them as a result of the incident. When nurses felt they were blameless for the incident and they could not have done anything to predict or prevent the death occurring this acted as a significant psychological defence mechanism. This was most apparent in drug and alcohol services where some nurses acknowledged that some of their clients were always at risk of dying unexpectedly given their high-risk lifestyles. Some of this group of nurses said that knowing this helped prepare them for the likelihood that some of their clients would die early.

Michael (02) working in substance misuse services described his experience of working with high-risk clients and the clinical process he implements to try and prevent a client's death. He describes how once he feels he has done all he can reasonably do to ameliorate the likelihood of a client taking their own life it reduces his anxiety and the 'personal burden' he feels.

"It can be at the time when I'm dealing with that person and they are sitting in front of me saying they want to die, it can be, but I think the more you do it and that you know what to do in those situations, and you share that information, it lessens the personal burden because you've shared it and you've done your bit and you've put the risk assessment in place, you've talked to them and explored protective factors, you've encouraged them to keep themselves safe, you've offered extra support, you've referred them to a health link worker for example or you've offered other

services or signposted other services, you've documented what you've done and put it in your care plan, the GPs alerted. So I think that once you've done all that then really eases the burden, if you like, because you know you've done all you can do. At the end of the day it is part of the job that is that person's depression that is where that person's at the time. There is only so much you can do. As long as you've done everything you can do you have to sit back and say I can't do any more."

Others also acknowledged the limitations when working with someone in the community and sometimes merely seeing a 'snapshot' of the clients' life could not always enable them to determine the likelihood of a death occurring. This perspective seemed to help them reconcile why they were not able to prevent the death occurring.

Jacky (13) described how understanding her involvement in the clients care, in the context of his overall life, brought for her a greater insight into the limitations of being always able to prevent a death.

"Our senior psychologist in particular, he was also reaffirming that really and talking about the fact that as professionals we have a very small part in somebody's life and sometimes we think we have a massive role. It's not, it's a very small role and that you do what you can within the remit of that and you can't save everybody and you can't always prevent people from taking their own lives and that he was a very tortured soul."

Janet (10) also described that, despite caring for her clients, she has to accept that sometimes, for some clients, death will occur almost as an inevitability of their lifestyles.

"Looking at things realistically, oh well ok I saw this chap, on the surface he was doing really well, but I couldn't have predicted that whatever happened over that

period from when I last saw him to his death that something would have triggered him to go off and use. I have to take a step back and look at it. You know, we work with high risk clients and historically there have been many kind of deaths by misadventure. We have to take a step back and then whatever you could have done you can't control these people and they will do whatever they do."

This concept for some of inevitability was explored further as I wondered if this might lead to complacency in clinical practice. Janet (10) explained that whilst you need to recognise that deaths will occur, it would not prevent you from providing optimal care. However she felt a need to distance herself from some of the unpredictable actions of her clients.

"They are high risk clients aren't they and what they are doing is risky, so I think that's what kind of grounds you in the end and you realise that no matter how many risk assessments you write in a way it's a bit of a paper exercise because you can't protect them and you can't predict their actions and you have to become a bit distant from it."

5.4.5. Summary

Nurses, who were able to develop a perspective on the death that rationalised their practice, appeared much more resilient to the likelihood of developing any detrimental psychological effects to the death. The ability to feel that they could not have done anymore appeared to psychologically prepare them for any subsequent professional scrutiny. This appeared most prevalent in drug and alcohol services possibly due to the nature of their client group and a greater exposure to deaths. An aspect that emerged was whether nurses, who were repeatedly exposed to deaths, developed a defence mechanism by accepting that these deaths would occur and subsequently this manifested as a more 'mechanised' practice. Those nurses who

said that their responsibilities and accountabilities as a nurse were paramount refuted this possibility. This was further mandated by their acknowledgment that their practice would be scrutinised if an adverse event occurred.

5.4.6 Organisational blame and professional scrutiny

Following the initial incident most of the participants were involved in an internal review of the case by their employing NHS Trust. Many of the nurses involved in this process found it extremely stressful and anxiety provoking frequently fearing they might be blamed for the incident. This fear of blame was a predominant feature for many of the nurses involved in the study.

Participants also frequently described that their anxieties about the internal review were often unfounded and subsequently suggested that the process of scrutiny was helpful in that it demonstrated that nothing could have been done differently to prevent the death. This validation by their employers provided them with increased levels of resilience for any further scrutiny through the coroners hearing. Some nurses said that they wanted the process of internal review to highlight where other services or agencies had, from their perspective, failed the client. This suggested that whilst they wanted the review to validate their practice they did want it to demonstrate potential deficits in the practice of others. Participants also described how they used the process and outcome of the review to reflect on their own practice.

Sarah (09) describes how she found the process beneficial in assuring herself that she could not have done more for the client. She also demonstrates how she has reflected on her practice and her involvement in the overall care of the client.

“I suppose for me it was helpful to scrutinise all of the things that had been put in place to help that particular patient and to be able to say there wasn’t anything else

that could have been done by our service at that time. I suppose as well the scrutiny did help me about being able to look at myself and how I'm involved in the process."

Janet (10) also identifies that the review can bring about positive long term changes to your practice by suggesting that, whilst the outcome may not have been different for the client some improvements to practice can be made. She affirms the important validation from the internal review when clinical practice is found to be acceptable;

"I think that if there's an internal review you do still feel that you could have done things differently and sometimes that's a good thing because it changes the way you work for the better when you realise actually I did everything I could and I couldn't have done anything better kind of reiterates to you that your practices are ok and that you have done the best you could have done with that client, so yes."

Nurses were not always convinced that the findings of the internal reviews and specifically the recommendations were communicated widely, and therefore, did not lead to changes in clinical practice. They also identified that, once they had given evidence to the internal review, rapid feedback on their practice would have been beneficial in alleviating their anxieties.

Whilst the majority of the nurses involved in the process of internal scrutiny had their practice validated those who did not described a much more traumatic experience. Their perspective was that they were blamed by the organisation for the incident and this was neither fair nor appropriate. The view of being blamed largely manifested as a sense of injustice and a concern for their future career. John (03) described how he felt that both on a personal level and for his services, he was being unfairly criticised and judged. Whilst John (03) accepted the services might have been unsatisfactory he perceives that the level of criticism was disproportionate.

“It kind of made me feel that other people were looking at my unit and me and being overly critical because given the fact it was a fairly serious issue - it got to board level as well - so the board were particularly concerned about it as well. They’d got a report that was fairly damning so it was about what the clinicians would think about my service, what the board thought about my service so because I accepted it was my responsibility for the unit, then I felt that other people were judging me.”

Those nurses who had an adverse experience spoke about how they felt blamed by their Trust. Whilst these nurses were in the minority it was their poor experiences that seem to influence the expectations of others. Specifically that nurses expected to be blamed by their organisation. Generally nurses seemed to expect that the process of scrutiny would result in them being severely criticised, however the reality was that the majority did not have any adverse remarks made against their practice. The absence of not having any detrimental comments was welcomed however these nurses said the process would have been more positive if the employers made a more public affirmation regarding their practice. In real terms they suggested this would mean that the nurses could be thanked or even complimented where their practice was good.

A consistent concern for nurses was a fear that the scrutiny may ultimately result in their inability to maintain their NMC registration. The nurses described how, through this process, they felt a heightened sense of accountability, which was disproportionate to their normal work experiences. This fear for their registration was for many one of the most prevailing factors in adversely affecting their psychological wellbeing. The final affirmation from the coroner that they could not have done more combined with their employers response ultimately led to the cessation of any ongoing anxieties on this particular point.

Sally (08) describes how fragile maintaining your professional registration can feel, particularly if you are not believed throughout the process of scrutiny.

“Yes, because I would lose my registration. If someone would believe this I’d lose my registration. I don’t know, that’s always my immediate fear if something goes wrong.....No one ever mentioned that... It’s not the sort of thing you mention but I think it’s the natural fear if anything goes wrong your registration’s very fragile and you try to do everything correctly to hold onto it as well. I am very aware that you achieve it and you’ve got it and could quite easily be taken away.”

Jo (15) expressed a sense of frustration when describing the circumstance of a client who impulsively took their life. The sentiments expressed by Jo are similar to Sally’s in their perception of how at risk their professional registration feels. Jo seems to imply that the patient’s action may determine your registration. Jo also infers a level of passivity or lack of power to demonstrate how she can maintain her professional responsibilities.

“You’re very close to losing your registration on a whim of a patient.”

Some nurses seemed to adopt a fatalistic approach to the inevitable scrutiny that would occur as a result of an incident. Janet (10) told me how she felt that it was an expectation that your practice would be reviewed if a death occurred and this was the stark reality of accountability in nursing.

“At the end of the day you know that you are accountable and you know that if there is a death that you’re practice is going to be looked at and you know that the possibility of going to coroner’s is quite high so even with the more stable clients, you always are kind of aware, there’s always that fear within nurses.”

5.4.7. Summary

Fear of blame and the possibility of the clients’ death leading to a disciplinary and professional conduct issue was a concern for many nurses. However this fear was

disproportionate to the actual reality of their experiences. The majority of nurses involved were neither criticised nor blamed for any of their actions in relation to the care and treatment of the client. The process of scrutiny provoked significant anxiety but on reflection most nurses recognised this as a necessary process given that a patient had died. They also stated that they had used this as an opportunity to reflect on their own practice.

5.5 Section 3 – The impact of the death and its aftermath on the mental health nurse's practice

5.5.1. Introduction and synopsis

One of aspects of this study was to determine whether the nature of the nurses' experiences led to any changes in their clinical practice. I was also interested in the nurses' experience of how the organisation had responded to and learnt from the incidents, particularly to ascertain whether any training needs were identified.

Many of the respondents described increased levels of vigilance when recording the clinical notes and formulating risk management plans. There did not appear to be any consistent length of time for this heightened state, although for some it lasted until the conclusion of the coroners' court. For these nurses the court case seemed to represent an important symbolic closure to their experience.

When trying to understand why the nurses adopted these responses it largely seemed to be as a vehicle for mitigating the likelihood of being re-exposed to a similar incident. The prevention of similar events negated further feelings of anxiety; self-recrimination and blame that they felt were a personal consequence of the death. The death of the client and its impact led many of the nurses to give a poignant and

sometime tearful account of how they questioned their clinical involvement and whether they were somehow complicit in the death.

When asked to reflect on any learning from their experiences some of the nurses described that there were some positives aspects associated with these events. They also acknowledged that there were some learning opportunities for their employer particularly in preparing staff for appearance at court.

The participants were less able to easily identify how their employer had learnt from the deaths. There appeared greater clarity when identifying changes as a result of an inpatient death. Community based deaths did not appear to assume the same status in terms of organisational learning. They identified that Trusts relied too much on governance structures and should invest in working more closely with clinicians to really embrace change and maximise learning.

In discussing the experiences of the nurses it emerged that distinct areas of clinical practice were affected by the incident and the subsequent process of scrutiny. These areas were record keeping and clinical risk assessment and risk management. I will address each area in turn.

5.5.2 Record keeping

Almost all the participants identified that the most striking change in their clinical practice was a more meticulous approach to record keeping including day-to-day entries and the contents of the patients care plan. All participants were aware of the importance of record keeping prior to the incident but identified that their experiences had significantly altered their attention to detail to ensure more complete and contemporaneous notes. Lisa (06) articulates a common response from participants.

“I suppose you become more aware of the record keeping and make sure it’s really accurate and up to date.”

Many participants found their clinical records were subject to detailed scrutiny both from their employer and, in some cases, the coroner and lawyers representing the family of the deceased. This scrutiny would then inform lines of inquiry where nurses had to explain and sometimes justify why they had made a particular judgement or observation about what was happening for their service user. This analysis by others was found to be particularly difficult and subsequently appeared to result in an almost immediate change in their clinical practice.

James (05), a community nurse, describes how the incident was an immediate reminder about your responsibilities as a nurse and how your records are used to determine the standard of your practice. This realisation seemed to elicit some concerns for James in the judgements that may be formed by others;

“I mean we do have so much paperwork it’s untrue but kind of reiterate to them that actually it is important because the bottom line is if something were to happen to someone this is what you’ve got to show what was happening with that person. And also whether you are doing your job properly as well.... Yeah, it’s true in a lot of ways but the reality is what you are actually doing with people that is whether you’re doing your job properly or not but the thought of there will be a lot of judgement on whether you were or not based on what you put down on paper is kind of an awful thing to think. You want things to reflect what you’re doing but the thought that if you didn’t put a few things down in someone’s notes and something happens, then people will be looking at things differently. It’s quite a scary though really.”

One of the areas that seemed to concern James is how the volume of paperwork that nurses are exposed to may sometimes mean that not all of it is thoroughly completed.

He infers that any accidental omission of information may lead to heightened scrutiny or criticism.

Whilst the volume of records was discussed by a number of nurses some considered how the record keeping culture of the clinical team at the time of the incident was relevant and how this impacted on their own practice. Sally (008), a junior staff nurse at the time, discussed how her own practice in the immediate management of a patient's death was influenced by the team culture.

".. It felt like it was really thorough and I was really grateful for being on a ward that was so efficient. I didn't have the sense so strongly then of that, but post that knowing how much coroner's court or the solicitor picked at it, I thought gosh if I'd been on another ward I don't think it would have been that fast. I was convinced it wouldn't have been, because we even started to write down times of exactly what was happening at that time, and quite often in an emergency that doesn't happen because you're all busy."

Sally's reference to how much the records were scrutinised by both internal and external reviewers was an example of the principle reason why the nurses changed their practice. Participants identified that changes in record keeping were almost entirely due to a feeling of a need to defend their own practice should they find themselves in a similar experience again. Frances (04) spoke about how this need to defend one's own practice was an unhelpful way to construct the importance of clinical record keeping. Frances' quote below (04) suggests how the culture of the organisation can use record keeping as a pejorative term to motivate staff rather than identifying it as a cornerstone of good clinical practice.

"I also think that the term if you haven't recorded your notes properly you would end up in coroner's court and you won't be able to defend yourself...we use the coroner's court as a threat quite a lot in conversation in nursing.....It's used

quite a lot in So if you haven't recorded it right and you have to stand up in court and answer questions about your practice it's used like a punishment and I've seen that a lot."

Many of the nurses cited that they had become more defensive irrespective of the organisations view. This seemed to be borne out a need to defend ones own practice and overtly demonstrate how they were working with the client. Jo (15), a nurse who worked within the criminal justice system described how her experiences had led to her applying what she called the 'Your Honour' test in her clinical entries. She described how this was a conscious approach to every clinical entry to see how it would appear if she had to defend her clinical views in court. She also described how her coroner's court appearance led her to question retrospective entries she had made;

"I think the defensiveness comes out in very well worded entries in clinical notes and matters and because I'm doing some work forat the moment, going back, and I read some of my old stuff and I thought I could have tweaked it here and tweaked it there to say not "they are" but it appears that...it seems that...it's reasonable to suggest. To go very much down the solicitors way of thinking and unless I know its fact then it's never stated as fact ever."

Some nurses adopted a more positive perspective of the need for improving their record keeping. Jo (15), whilst acknowledging how the experience had made her more defensive identified that this had also led to becoming a more accomplished nurse. She described how the whole process of scrutiny and subsequent changes in her practice led to her feeling she had a greater level of awareness regarding her own professionalism.

"I suppose it is that when I first went into nursing even though I was band 6, I used to say I'm just a nurse, just a junior because I'd seen these senior clinicians

around and I find that I don't do that anymore. I think that the experience has made me confident, very confident nurse actually."

Other nurses also concurred that this refocusing on the need for good clinical records should not always be seen as a negative by product of a sometimes unpleasant experience.

Jacky (13) reflected on experiences that had brought about changes in her clinical practice and how these had reminded her of the specific responsibilities associated with being a registered nurse.

"So I think it's just made me more aware of the legal aspects really of what happens in a case. In a way it's been a positive learning experience if you can call it that in terms of what it teaches you about the kind of legality of your role and what you do and what happens when things like this happen. And they do happen."

5.5.3 Summary of record keeping

Nurses described how a more diligent approach to record keeping was one of the most tangible changes to their clinical practice post incident. For many this was borne out of a need to more overtly demonstrate how they are working with a service user and establish a rationale for the judgments and observations they make about the clients care. These changes were largely seen as a need to defend their practice although some nurses took a more positive perspective on the benefits of sound record keeping.

A further factor that appeared to influence the approach of some nurses was the perceived culture of either their respective team or organisation to record keeping. Those nurses who worked in an environment where they took a more detailed

approach to record keeping appeared to have a more positive view of their experience, their detailed records affording them a level of protection from their ‘scrutinisers’.

5.5.4 Risk assessment and management

Risk assessment and risk management has been seen as one of the cornerstones of clinical practice in mental health nursing for a number of years. This has led to an increased expectation regarding mental health professionals ability to somehow predict the likely behaviours of their clients, particularly in relation to self harming, suicidal or violent behaviours. All participants within the study acknowledged this perceived heightened sense of responsibility in relation to their clinical risk assessment and risk management plans.

The discussion with nurses and the analysis of the data elucidated a number of specific areas that most of the nurses referred to when considering risk. These areas were;

- Did they miss any signs or indications of the likelihood of the death occurring and the ability to predict the incident
- The impact on clinical practice

5.5.5 ‘Did I miss anything, could I have done more?’

Many of the nurses interviewed described how one of the most compelling questions they asked of themselves was whether they had missed a ‘clue’ that would have indicated the client was likely to die. The level of self-reflection on this point was probably one of the most prevailing factors that emerged from the interviews. It also

elicited some of the more poignant emotional self-descriptions of whether, if they had acted differently, the client may have still been alive.

Barbara (01) a very experienced nurse in substance misuse services described how the death of a client led her to question whether she was competent to do her role and immediately blamed herself for the death of the client;

“ I can remember thinking I can’t do this job, I am clearly doing something wrong, this person has died because of me ”

This immediate sense of self-recrimination regarding the possibility that they had missed something was common. Nurses repeatedly asked themselves had they ‘missed any signs’, or ‘could I have done something differently’. This self-analysis would include reflecting on their last meeting with the client in an attempt to identify whether there was some clinical indication that they had missed. Janet (10) described the sense of anxiety and the self-analysis that commences once you hear about the death of the client.

“There’s this immediate panic then...Yeah, you kind of do it while you can but you know that after a certain point when you know that you have to notify or you put that on the database that the person’s died, you can’t input anything else, so you are then looking and thinking through every note and seeing if you’ve missed anything, should I have acted differently on that, you know on the interview with them should I have picked up on what they said then.”

Janet (10) outlined how she considered various aspects of her last clinical contact to ascertain whether there was any indication about the pending incident. Janet’s experience was one that was commonly shared by her peers. Frances (04) understood that one of your immediate responses is to question your clinical judgement.

However she suggested that with certain clients the risks can change quickly and that can limit your ability to manage the situation;

“I know the risk assessment is only as good as the minute that you’re doing it or the day that you’re doing it and that things can change with people overnight and it could be quite different if you were to repeat the risk assessment the next day.....we don’t know what people are doing, we only know what we are presented with.”

Some of the nurses, whilst trying to validate their practice, also outlined how the death was completely unexpected. They felt that they were confidently managing any relevant risks with the client and that incident was neither predictable nor preventable. Janet (10) shared how she recognised that some of the clients she works with have high-risk behaviours. However her experience has been that those that she has considered less of a risk went on to die unexpectedly. Janet appeared to use the term ‘risk radar’ to describe which clients she would be more concerned about in relation to their risk.

“I got back after Christmas and there was a report that he’d been found in the stairwell of a flat having overdosed on heroin. So you know, it was a real shock. You kind of have clients on your caseload who are always on your risk radar especially over holidays and you know you’re always worried and think I hope they are ok, if they are homeless and that you’re always worried. It’s always the people, often, that are not on your risk radar so it was initially a real shock.”

This sense of unexpected death was not uncommon; however other nurses discussed how the death was not a surprise. Some of the nurses described how due to either the nature of the clients lifestyle or the difficulty in maintaining a level of stability in both risk and mental health there was a constant concern that an incident might occur. For some nurses this would manifest as a feeling of helplessness and powerlessness to effect any real change to the client’s life. Sarah (09), a senior nurse

in substance misuse, described working with a young mother who died as a result of an overdose.

“It was really hard I think because we all knew her really well and could feel that this was going to happen or something like this was going to happen.I wasn’t surprised I suppose, it was always on the cards, she did self harm, well not self harm as such, but certainly some suicide attempts and I think perhaps this time she did it and didn’t get away with it. I’m not surprised, but just think it was incredibly sad because she had children and she’d got through this kind of thing before but I’m not saying it would have necessarily stopped it ever happening.”

Some nurses acknowledged that, for some of their clients, they had a sense of inevitability that at some stage the client may die prematurely. Jo (15) spoke of a client she worked closely with who had significant difficulties in coping with day to day living and was almost permanently distressed by his experiences. She also identified that such was the level of distress the client experienced that in some ways his death could be seen as a ‘relief’.

“Yes, I felt absolute relief for the young man because he was so psychologically damaged and it felt like all the weight off his shoulders and I just really felt for him, you know. That’s the only way I can describe it.

Were you surprised?

No

Not at all?

No, it was going to happen one day whether intentional or accidental it was going to happen, definitely.”

Lisa (06), when considering the broader nature of mental health services, further affirms the likelihood that even with risk assessments death may occur;

“I just think that within this service there are things that are going to happen from time to time and you know even if you’re doing risk assessments or whatever there’s going to be cases,”

5.5.6. Summary

Many of the nurses interviewed identified a frequent and consistent experience of questioning themselves regarding the assessment and management of the client’s risk. For several of the nurses this would include a significant emotional investment in ascertaining if they were somehow to blame or at fault for the incident; possibly as a result of missing some overt or subtle indication that the client may take their own life. Ultimately the nurses did not feel that they could have prevented the death.

Other nurses recognised that some of their clients represented a relatively constant high risk due to the nature of their lifestyle or ill health. Those nurses who worked with this client group described a sense of powerlessness about their ability to positively effect the likelihood of death occurring.

5.5.7 The impact on clinical practice

Many of the participants described how the death of the client led to a heightened sense of vigilance when undertaking risk assessment and implementing risk management plans. This was seen as an important factor in mitigating the likelihood of a reoccurrence of another incident and ameliorating any possible blame that could be associated with a further incident.

Janet (10) shared with me how her ‘risk radar’ was heightened for at least a month after the incident and that no clients ‘went down to zero’.

“For a while you are much more vigilant with everyone and you are looking for clues that you are thinking, ok they say they’re not using gear, their urine samples are ok, but what if when they leave here they are using, you know, and you do become a lot more suspicious I suppose, you just worry about then is something else going to happen that you’ve not picked up on and is it going to result in another coroner’s..... So yes, you definitely become more vigilant about not being complacent, you don’t want to become that kind of feeling safe because they say they are OK, you’re kind of looking for clues.”

Janet infers that relying on what the client says to feel assured about risk is inadequate and that she looks for more ‘clues’ about what else might be happening for the client. Similarly Mathew (07) outlined how his attention to risk became almost the sole focus of his clinical work up to the conclusion of the coroners hearing some months after the death. He also makes reference to his confidence in risk assessment being dented by the incident;

“I initially became very risk averse, as it were, so I was thinking this with colleagues as well, and everything labelled as a risk kind of took me back and that you’ve got to do your risk assessment every hour and that kind of stuff and that lasted for a couple of weeks maybe after the coroner’s thing and just kind of getting a grip really and reign yourself in because you’re going to be doing risk assessing and you won’t have time to do anything else.”

This conscious decision to prioritise risk plans over other elements of the care plan was shared by Sarah (09) who described how she adopted a more proactive approach to risk management

“I can remember being aware that I was thinking about a client in a similar situation with children whose mental health was deteriorating and I was possible a little bit

over zealous in my wanting to put in a safety package and risk assessment and I can remember thinking then I'm doing this because of my patient"

Sarah (09) and others also identified that, whilst there is an element of protecting themselves by adopting more diligent approach to risk, there was also an implicit acknowledgement about needing to be sure that they are maintaining the welfare of other clients by keeping them safe. James (05) shared how he had difficulty in re-balancing his clinical practice when the incident reminded him that sometimes people we work with may die.

".....then that sudden fear around the rest of the people you work with as well on my caseload. Suddenly thinking you know this is a real thing that happens to people. How worried should I be about everybody else? Should I be more worried that I am? And then obviously you know later on not initially then, you then worry well am I too worried and anxious about people and then trying to get that balance back really was quite difficult."

The experience of nurses being overly concerned with risk seemed to diminish over time. Many expressed that they recognised this was both unwarranted and unsustainable. However whilst the focus may have diminished participants did affirm that they would generally continue to ensure risk assessment and risk management plans were carefully documented and recorded in line with their employers' policy. Michael (02) said that for him, ensuring that he had followed all the policies and evidenced his decision making process was an important aspect of 'lessening the personal burden' he felt as a result of a patients death.

Participants suggested that there was a greater acceptance in mental health services that sometimes people may die unexpectedly and more mature organisations would negate staff feeling 'blamed'. However the response from the employer was almost inevitably determined by whether the quality of care could be evidenced through the

clinical records. Martin (14) gave his perspective based upon his twenty six years experience in mental health nursing;

“In recent years there is more of an acceptance that SUI’s will happen and people will kill themselves. In saying that there’s a much heavier emphasis on risk assessment, risk planning and risk documentation so on one hand there’s an acceptance and actually saying to people we accept that some of the people you are going to be working with will kill themselves and maybe kill other people, we accept that and you will not be blamed for that, providing that all the documentation and risk assessments have been done....”

Martin’s view would suggest that the concerns about management of risk go beyond the individual practitioner and directly influence the response of the employer.

5.5.8 Summary

Many of the nurses interviewed described a process where they would become hyper vigilant in relation to risk assessment and risk management. This seemed to be as a result both of not wanting a reoccurrence of a similar incident together with for some a temporary loss of confidence in their ability to manage risk. The amount of time this level of vigilance lasted varied from person to person, however the conclusion of the coroners hearing with a validation of their practice seemed to be an important factor for the nurses. Whilst the nurses gradually returned to a level of clinical risk activity commensurate with their performance pre the incident many did acknowledge that they remained more diligent in the completion of relevant documentation for risk management.

5.5.9. Learning lessons

The participants were invited to comment on whether they felt any learning had taken place for their employer as part of the incident. A few of the nurses commenced with identifying that the experience had been a positive learning opportunity for them. The learning had been borne out of a greater awareness of their responsibilities as a nurse. This aspect related to their status as a professional and a heightened recognition of accountability as a result of giving evidence at court. The learning appeared to relate to two main areas. Firstly the technical element of the role, notably keeping good clinical records and ensuring risk assessment and management plans were accurate and contemporaneous. Secondly a more personal reflection that the role can be difficult and challenging and that sometimes this can lead to working with clients who will die.

Whilst some nurses reflected that this had been a positive experience most found the experience of a patient's death and the subsequent experience of attending a coroners court highly stressful. Nurses identified that their anxiety could have been reduced with greater preparation. Martin (14) shared how greater support in understanding what would happen at court would have made his experience less difficult;

"I suppose it was one of the most stressful things I have done in the professional sense if not the most professional thing, so to have come through it does make you feel sort of more confident. It was a learning experience and one that could have been made a little bit easier with a bit more support in the first place."

Martin suggests that he felt more confident as a result of the experience although despite having 26 years of experience, he clearly suggests support would have made the experience less difficult. This need for practical support was emphasised by a number of nurses. Participants also felt it would be beneficial to see the court room before the day of the hearing so they could have a greater sense of understanding the

environment. Participants suggested that their organisation should ensure that nurses are orientated to what the court process will include, notably; who will be present and what the various roles of individuals are within the court. This was felt to be particularly important in relation to members of the deceased family. Nurses described how they would have felt more confident if they had known about this in advance and perhaps given an opportunity in advance to think through what questions may be raised and how these could be addressed. Sarah (09) spoke about how she felt her organisation may want to provide more training for staff particularly regarding possible interactions with the deceased family.

“I suppose I suspect it’s going to become a more and more regular occurrence that nurses are asked to attend coroner’s court and perhaps we certainly as a Trust put on any training about what that will be like.....I do think it comes as a real shock from my experience talking to nurses to say that you do realise that there may be family there and they hadn’t even thought that there may be family there too and they can ask you questions. I think that’s probably one of the huge anxieties because nurses feel they will be blamed and they might be asked to answer questions they can’t answer or that there might be full on confrontation either in or outside of the court, so I think that would be useful as it’s one of the main anxieties.”

Sarah (09) raises the concern that nurses feel they will be blamed and infers that strategies for dealing with this situation would be beneficial. The implementation of practical measures could facilitate an important chance to reduce anxiety and further ameliorate self-recrimination and feelings of blame.

When considering whether their respective organisations had learnt from the incidents there were very mixed views. Those staff whose incidents involved deaths within in-patient settings suggested that there was evidence of the Trusts responding to events. John (03) suggested that the in patient death was a ‘wake up call for the Trust’ and it had ‘lots of positive benefits’. Nurses working in the community were

often less able to clearly articulate how the Trust had learnt from the incidents. Participants suggested that organisational structures in mental health services make it more complex to embed learning. They suggested that their organisations could invest more in providing feedback to individual teams, targeting the clinical coal face rather than a perceived over reliance on governance and committee structures that sometimes would not ultimately change clinical behaviours.

John (03) described how it was imperative to learn from incidents and not to lose sight of the impact it has on all those involved.

“So for me, it’s a fairly sobering thought. Somebody might throw in constantly in discussions with staff when they become a bit nonchalant about incidents, I will say you need to meet a family whose is never going to be the same again, because I can kind of say it from experience and it’s not some scenario you fabricated, it’s kind of you need to meet a family who this has happened to. For me, I’ve carried the torch since and I probably will always carry the torch because it’s probably one of the most symbolic issues in my nursing career to tell you the truth.”

5.5.10 Summary

Participants consistently identified that they would have benefited with greater preparation for their appearance at a coroners court. They outlined how this would have increased confidence in understanding what may be expected from then. Some nurses identified that the incident and subsequent process of scrutiny had afforded them learning about themselves and their clinical practice. This learning was not always evident within their organisation and seemed to be more tangible from an organisational perspective when the incident appeared to be related to an inpatient death.

5.6 Conclusion

This chapter has identified that following a suicide or unexpected death nurses experience a number of changes. These include changes in clinical practice but perhaps more importantly some adverse effects in their emotional and psychological wellbeing. For two of the participants the death has a continued impact on them. The collective experience of the nurses suggests some potential areas for improving the effects of unexpected deaths and suicide and the aftermath. Chapter six will discuss the implications of the findings and establish how the experience of the participants advances knowledge in relation to psychological consequences of unexpected death, suicide and professional scrutiny.

CHAPTER 6

DISCUSSION AND REFLECTIONS

6.1 Introduction

This chapter discusses the grounded theory findings outlined in chapter 5. It demonstrates how this study has contributed to knowledge in relation to nurses who have experienced an unexpected death or suicide and been subject to professional scrutiny. It identifies a number of areas that have not been previously recognised in other research pertaining solely to mental health nursing. Moreover it affirms that when compared to non-health based literature some of the findings may enhance knowledge across a broad range of professional groups where staff may experience exposure to unexpected or traumatic deaths. This includes the development of a theoretical framework that identifies specific time points when staff, without appropriate ameliorating factors, are more likely to experience heightened levels of psychological distress.

To facilitate ease of reading the chapter is constructed in the following way;

- Summary of key findings and the context of the research
- Discussion of main findings
- Summary of discussion and contribution to knowledge
- Implications for practice
- Reflections on methods
- Implications for further research
- Conclusion

6.2. Summary of key findings and the context of the research

The present study was undertaken in the absence of any significant research on the effects of unexpected death and suicides on mental health nurses. Specifically the study was interested in the impact on their psychological wellbeing in the aftermath of a service user's death and the subsequent process of professional scrutiny. It is recognised that specific research on mental health nurses is limited despite the knowledge that many mental health professionals will work with someone who will take their own life (Gilje et al 2005, Tillman 2006). A review of the non-health based literature further informs the study and identifies that several other professional groups are involved in unexpected deaths and subsequently subject to professional scrutiny.

For participants in this study, the experience of the death and the subsequent process of scrutiny was the most difficult event they experienced in their entire career. Several of the participants were distressed when sharing what happened to them. This was borne out of a combination of their own sense of personal distress and feelings of sorrow and loss for the client. This was most evident when the nurses had developed an emotional closeness and connectivity with the service user.

For many of the nurses, the death of their client had a significant impact on their clinical practice. This included a heightened sense of trying to prevent further deaths occurring through more assertive and comprehensive risk assessments. They also undertook a number of 'defensive' procedures to demonstrate they were overtly discharging their professional responsibilities. These behaviours were implemented to try and avoid re-exposure to the distress they experienced through the death of their patient.

The death and subsequent process of professional scrutiny also transcended the personal lives of participants. This would impact on how they behaved at home and for some, was apparent through changes in their emotional and psychological wellbeing. For two of the participants intrusive thoughts continued despite some years elapsing since the event occurred. The manifestation of a range of emotional and behavioural symptoms could suggest some of the nurses may have experienced psychological difficulties that could be associated with acute stress and anxiety reactions, adjustment disorders, depression or psychological trauma. The nurses also described a psychological journey that commenced from the onset of the incident to nearing a place of psychological closure at the coroners hearing.

One of the principle concerns for staff that underpinned many of their responses was the sense that they would be blamed for the incident and that ultimately this could lead to a disciplinary process and perhaps loss of their nursing registration. This fear was compounded for some by a view that ‘management’ may be looking to apportion blame. In reality none of the nurses involved in the study were subject to any disciplinary process. The nurses provided insight into what enables support, this included clinically credible experienced managers, supportive teams and for some an understanding social and familial support network.

6.3 Discussion of main findings

The next section will concentrate on the principle categories that emerged from the data. This will enable an opportunity to explore the theory developed within this study and compare and contrast against the existing literature.

6.3.1. The psychological experience arising from the death

An important element of this study was to understand any psychological consequences arising from the experiences of the participants. The nurses described varying degrees of psychological distress. Commonly this distress included feelings of shock, acute anxiety, panic and fearfulness about the implications for themselves. This concern for self manifested after initial feelings of concern and upset for the client.

After a period of initial shock, participants expressed feelings of depersonalisation or emotional detachment and a need to understand why the death had occurred. These initial responses appeared to try and mitigate the personal distress they were feeling. The quest for more detailed information seemed to assist them in making sense of their reality. This need to make sense of and understand the death is a common experience by both professional workers and carers and these findings support other studies. Begley and Quayle's (2007), phenomenological research of 8 adults bereaved by suicide identified 'sense making' as early stage of coping with the trauma. Therefore it is relatively well recognised that the findings regarding the initial experience of the nurses is not uncommon outside of the mental health nursing literature. My findings identified a slight variance in that community nurses described a heightened sense of 'needing to know' as they were receiving the news of the death through a third party. The level of uncertainty about the precise nature of the event seemed to raise the nurses' anxiety. This is reminiscent of Scott et al's study (2009) of 31 clinicians interviewed using a semi-structured questionnaire. They describe this process as a period of rapid inquiry where the practitioner endeavours to understand what has taken place.

Inpatient nurses were fully aware of the details as their situation was compounded by the fact they were dealing with managing the incident and/ or preventing the death of the patient. They were therefore exposed to the physical reality of the situation,

namely the implementation of resuscitation techniques and other clinical interventions, to prevent the cessation of life. This additional dimension and in particular exposure to the body brought physical manifestations of anxiety and stress during and immediately after the incident. The presence and experience of such behaviours and feelings is relatively common in emergency and untoward situations as identified by Raissin et al (2005). My findings further substantiate Raissin et al's (2005) qualitative study of the effects of severe medication errors in 20 nurses. His study identified a similar reaction in participants. The reaction being more pronounced when witnessing the physical impact of the error on the patient.

At the time of the study two participants continued to have recurrent distressing thoughts associated with anniversaries and other psychological triggers that reminded them of the incident. These experiences remained despite several years having passed. For these two individuals the presence of reoccurring experiences was markedly different to the other participants. The remaining thirteen nurses did not think of the cases on an ongoing basis. There only reference point for recollection would be either through a process where they were reminded (e.g. this study) or if a similar incident occurred. The experiences expressed by the two nurses with recurrent distressing thoughts would generally be more aligned to symptoms normally associated with PTSD. Takahashi et al's (2011) study of 531 nurses assessed on the Impact of Event Scale states that for in -patient nursing staff exposed to suicide, some are likely to experience significant mental distress, suggesting that within their cohort some 13.7% of nurses were at risk of developing PTSD. Contrary to their findings this study found there was little evidence (other than the recurrent thoughts described above) based upon the oral accounts of the participants that they experienced PTSD in accordance with relevant diagnostic guidelines (WHO 1992, NICE 2005).

Collins (2003) literature review of the effects of suicide on clinicians suggests that mental health workers who are exposed to vicarious trauma through their clients may

develop a secondary traumatic stress reaction. Collins (2003) refers to Figley (1985) suggesting there are three key areas for what he termed secondary traumatic disorder. These areas are; indicators of psychological distress, cognitive shifts and relational disturbances. The phenomena tend to be long lasting and affect the ongoing practice of the mental health workers, notably therapists. They argue that this ongoing process is exacerbated as the worker is re-exposed to further trauma each time they re-engage in therapy session where the clients outline their traumatic experience. Evidence from my study confirms there are similarities in that some of the criteria for a diagnosis of secondary trauma are evident. However there are also very clear differences. My findings identify that participants tended to experience their anxiety and stress at specific times and the symptoms would diminish after each key event. Another important differentiating factor is there would not be a continuing relationship with the client that could lead to staff being re-traumatised. Finally a further difference from Collins' (2003) work is that changes apparent in clinical practice would tend to be general changes in practice rather than person/client specific. The only specific client issue cited by the nurses was if they perceived a client to have a heightened propensity for suicide. This led to the nurses either wishing not to work with the client or, more commonly, becoming hyper-vigilant with the risk management process. This aspect concurs with other studies and will be discussed in more detail in section 6.3.7, changes in clinical practice.

Avoidance of cases or developing coping mechanisms following tragic situations is prevalent in numerous studies across a range of agencies (Clohessy and Ehlers 1999, Gustavsson and MacEachron 2002). Wright et al's (2006) findings of 49 prison officers who had experienced a death in custody are typical of other studies. They found that those officers with more pronounced levels of distress would avoid working with similar prisoners. My findings confirm there are some similarities within the cohort of nurses. However there are also some distinct differences, they seem less likely as a social group to have developed overt coping mechanisms that would facilitate a maladaptive change in behaviour e.g. refusing to work with clients,

desensitisation to other clients, becoming task/protocol orientated. This was not universal across all the nurses as three described ways in which they felt they had psychologically disassociated with the risk behaviours of their client. Significantly this was apparent only within the drug and alcohol services. This appeared to be in response to recognition for these nurses that even with good care and interventions, the high risk and unpredictable behaviours of the clients may still lead to deaths occurring.

Behaviourally and cognitively the distress manifested in various ways including sleep disturbance, intrusive thoughts, reduced appetite and an inability to relax due to feelings of constant tension. Evidence from this research confirms other studies across various professional groups where the individual has experienced an adverse event (Chemtob 1989, Regehr et al 2002, Tilman 2003).

6.3.2. Error and its significance

The psychological, emotional and behavioural responses identified by participants in the study echo the literature on second victims (Scott et al 2009, Wu and Steckelberg 2012). There are clear similarities between many of the core features notably feelings of anger, guilt and frustration. Equally many of the areas associated with the impact on personal and professional lives are also evident.

Most second victim literature pertains to the consequences of a clinical error. Participants in this study said they would not see the death as a result of an error arising through an act or omission of care. This is a distinct and important difference. The participants did follow similar psychological responses, which can be illustrated through feelings of guilt in the context of second victim studies. However, in my study the feeling of guilt was more associated in participants trying to ascertain if they had missed some indication that the event might occur. In essence this was an

attempt to understand if their assessment and management of the potential risk was appropriate. 'Second victim' studies and feelings of guilt are generally concerned with an overt recognition that an error has occurred i.e. that the clinician did do something wrong (Wu and Steckelberg 2012). What this suggests is that whilst the emotional and psychological consequences are the same, the catalysts to the effects are different.

Utilising Lazarus and Folkman's (1984) model of coping, the findings of this study show nurses predominantly adopted emotion-focussed coping. That is they were unable to directly remove the stressor (the death and subsequent inquiry) and therefore applied a more emotive led response to the situation. Edrees et al's (2011) survey of 350 health care workers experience of medical errors suggests that emotion focused coping is more likely to result in staff seeking support, taking responsibility for the event, guilt or avoidance behaviours. The literature on this coping style in relation to second victims indicates that the outcome is more positive if the individual accepts an error has occurred. What these studies do not address is how clinicians experience untoward events if do not feel they have committed an error. Evidence from my study confirms the nurses did not equate the death with a specific 'error' and this challenges other studies in their analysis of the experience of second victims and error.

Whilst not expressing an error had occurred some nurses stated that despite implementing robust care plans and risk management plans they recognised some clients still died. Those nurses who were able to rationalise that they felt their practice was reasonable seemed more able to prepare themselves for the process of professional scrutiny that would inevitably follow the incident. This sense of inevitability initially confirms the work of Appleby (2006, 2011). This Standing Inquiry considers all deaths by suicide collected through the Office for National Statistics. Appleby (2011) makes recommendation for both services and clinicians in improving practice regarding working with people who may take their own life. His

study suggests that for some high risk clients staff failed to pay due regard to the clinical warning signs. The inference being that this inattention to the client led to an avoidable death. This, it could be argued, is potentially a recognition that errors do occur with this client group. In contrast to this view participants inferred that their practice was clinically sound and that any ‘inevitability’ was due to the high -risk nature of the client group not as a deficit in their clinical practice or error. Perhaps unsurprisingly the views of participants differ to that of Appleby (2011) and this matter is addressed later in relation to areas of further research.

6.3.3. Previous experiences and the relationship with the client

Various studies across all sectors have suggested that previous experience of deaths can ameliorate the likelihood of adverse psychological effects on the worker (Hodgins et al 2001, Renck et al 2002). However other studies suggest that repeat exposure to deaths can have a cumulative traumatic effect on workers irrespective of their experience or length of service (Beaton et al 1999, Laposa and Alden 2003). Evidence from this study states previous experience of a death was not felt by nurses to be a significant negative or protective factor in how they felt about the death. A more important determinant of the response from the nurse was the relationship they had with the client.

Valente and Saunders (2002) meta analysis identifies that the emotional impact on nurses may be greater because of the nature of their relationship with the client. They suggest that nurses tend to have greater contact with clients and therefore have an increased likelihood of developing a closer relationship. The findings in my study support this but only to some extent. Nurses who, by their own admission, have developed a closer relationship felt a greater impact but this was not universal across all the nurses. Cognisant of non-nursing studies it is clear that the type of relationship is a factor; however my findings contrast with others and confirm that emotional

impact is more determined by the nature of the relationship rather than professional group.

Various studies have affirmed that the emotional loss for nurses of the death of a patient may be aligned to a bereavement process (Hamel-Bissel 1985, Collins 2003, Tillman 2006). Botega et al's (2005) study of 317 nurses using a validated questionnaire suggested that for nurses who have experienced a patient suicide these feelings may be heightened. The feelings described by nurses in this study including anguish, sadness and a sense of loss were clearly deep rooted for those who had the closest relationship. This concurs with previous studies. NICE (2005) when outlining the risk factors for developing PTSD identify the experience of a death of someone close as an aggravating factor. In contrast, the two nurses whose experiences most closely resembled a diagnosis of PTSD had a relatively distant relationship with the clients when compared to the rest of the cohort.

Outside of the health literature other studies concur with the heightened impact on the worker if they are close to the client. Gustavsson and MacEachron's (2002) study of child deaths and the effects on social workers suggests the death is more traumatic when the worker had strong personal feelings towards the child. This is supported in a variety of other studies (Green 1985, Snow and McHugh 2002 Ursano and McCarroll 1990). Ursano et al's (1999) mixed methods study of 54 disaster workers placed significant emphasis on the relationship between the worker and the deceased, identifying this as a seminal marker on whether the employee may experience a severe stress reaction. My findings build upon this important aspect by confirming the nurses affirm their organisational support structures were not sensitive enough to discern or understand this specific point. This is an interesting omission given mental health services are designed to work with people in distress.

6.3.4. Relationship with the family

A further key relationship that emerged from the findings pertained to participants meeting with the members of the deceased family. The specific nature of the interaction varied dependent on the rationale for the meeting. Some of the meetings would be in relation to providing information, and some would include offering support to the family. Others meetings, namely the funeral, would be as part of a need to show respect and sorrow for the clients death. Finally a further reason for meeting the family would be through the auspices of the coroners hearing.

All of these interactions were initially viewed as extremely stressful and anxiety provoking events. Nurses were extremely concerned that they would be subjected to anger and hostility from the family. This was informed by their perception that the family would seek to blame them for the death of the client. Nurses were trying to come to terms with their own emotional reaction to the death and when relevant, deal with the reaction from the family. This was most evident when they did not know the family or the existing relationship was already strained. A particularly difficult and stressful time was if the nurse was responsible for informing the family about the death.

The reality for individuals varied from nurse to nurse. In several circumstances the families' reaction was one of expressing their gratitude for the nurse's care and support to the deceased. This positive affirmation was beneficial in the psychological recovery of the nurses. However in the few cases where the family was hostile this exacerbated the nurse's feelings of guilt and a sense of blame. Studies from both within and outside of the health sector acknowledge the effect on the worker when dealing with grieving and hostile families (Collins 2003, Kilshaw 2004). Illustrative of this is Regehr et al's (2002) mixed methods study of childcare social workers that acknowledges the complexity of working with a grieving family. What these studies do not confirm is the exposure to families may be a point of extreme anxiety and

stress for the individuals involved. The lack of recognition is a missed opportunity to recognise the impact these interactions have on staffs' psychological wellbeing. Nurses also stated that they felt their employer was not sufficiently cognisant of the heightened state of anxiety and a greater awareness from them would have been beneficial. This was particularly evident at junctures that could be seen a potential flashpoints, notably breaking the news, giving feedback on internal inquires and the coroners hearing. This aspect will be discussed further in section 6.4.

6.3.5. Organisational support

All the nurses outlined the importance of a supportive team culture. It was apparent that this was not necessarily available to everyone but all participants spoke of its significance. These findings concur with other studies that identify a strong supportive team is recognised as a protective factor from developing adverse psychological reactions (Stephens 1996b, Regehr 2003, Scott et al 2009).

Support from management received a more mixed review. Very senior managers were perceived as distant and uncaring. Numerous national and international studies from within and outside of healthcare discuss the need for senior managers to be more actively supportive of staff following adverse events. Managers who were perceived as more experienced and credible were seen as extremely beneficial in supporting the needs of staff. The findings regarding a supportive management response are reminiscent of other studies (Regehr 2003, Bennet et al 2004). Participants also expressed a desire to hear from managers at an earlier stage that the incident was not predictable or preventable. They felt this intervention would have significantly reduced their anxiety and levels of stress. This perspective corroborates others studies that state positive affirmation from management is seen as a significant ameliorating factor in the psychological recovery of staff involved in adverse events. My findings therefore concur with Sirriyeh et al's (2010) systematic review of 24

studies examining second victims who identified this as an important factor in reducing staffs' psychological distress.

The importance of having appropriate psychological support that was timely and perceived to be beneficial was evident. Models of stress and coping mechanisms would suggest that provision of information and the opportunity to understand the emotional impact on the individual ameliorate the possibility of the development of a more pronounced psychological traumatic response (Lazarus and Folkman 1984, Van-Praag et al 2004). These studies are helpful and consider causation of stress and how individuals cope. However contrary to my findings they do not recognise the pervasive nature of stress and the subsequent experiences of individuals. Further publications (NICE 2005) suggest that caution must be exercised when considering when and how to offer psychological interventions for traumatic events suggesting that 'one off' debriefing sessions should not be routinely offered. Participants in this study, whilst recognising the importance of psychological support, argued that a more individually tailored response would be appropriate. They felt such an approach would be more individually beneficial and less likely to be perceived as merely a 'management response'. The findings in this study align to services that are being developed as part of work undertaken in response to 'second victims'. Scott et al's (2009) stresses the importance of timely individually tailored support for staff and describes a model for supporting staff after patient safety incidents. Significantly though, this has not previously been identified in the literature on mental health nursing. Senior nurses interviewed also spoke about the need for support and felt at times there was an organisational acceptance that they did not require psychological assistance. Studies show that senior staff should also be offered appropriate support although the findings of my study suggest we still fall short on this point (Bennet et al 2004).

6.3.6. Professional Scrutiny

Participants identified that the internal inquiry process was a key event in terms of significantly raising their anxiety about how they and the organisation felt about the incident. This heightened anxiety had a detrimental impact on the nurses prior to attending the internal review. They also felt their personal anxiety appeared to have gone largely unrecognised by their employer. This is an important finding as this specific experience of the nurses has been previously unrecognised in mental health nursing literature.

Participant's principle concern was that they would be blamed for either the death or for a significant shortcoming in practice. They feared this might lead to either a disciplinary process or a referral to the NMC. This perception of internal reviews is largely consistent across all health and non-health related literature (Stephens 1996b, Rallings 2000, DOH 2006). Regehrs et al's (2002) study of child health care workers identified that the process of review was the most difficult and stressful aspect of the whole process for the worker. Cartwright's (2008) reflection on her experience of public inquiries suggests the need for an organisation to find someone to blame is still a real perception for staff. The findings of this present study confirm the DOH (2009) view that employers must work hard at addressing this perception.

Whilst the nurses were very anxious about the internal review most welcomed it as an opportunity to validate their practice. This perspective is seen across other non-health inquiry process and is not unique to this study. Most of the participants also identified that their perception of the review process specifically their concern about being blamed, was unfounded. However this study was also consistent with other health and non-health studies in that for the minority whose practice was criticised they felt anger and bitterness towards the organisations (Reason 2000, NPSA 2006).

Brinkerhoff (2004) developed an accountability framework based upon an extensive analysis of the literature. He cautions that this can only be successfully implemented if health care organisations address a pervasive culture of blame as staff feel that accountability is only ever discussed in the context of situations that may have gone wrong. My findings support this view regarding nurses feeling that they would be held accountable for their actions. In reality this appeared to suggest by being 'accountable' they felt this actually meant they would be blamed. This concurs with Bovens' (1998) notion that for professionals being held to account for their actions was in reality a fear that they would be blamed for organisational deficits.

Numerous studies cite that staff feel blamed for their actions (Chemtob et al 1989, Wright et al 2006, Foley and Kelly 2007). The evidence from my study suggests that the reality is many nurses feel they will be blamed or criticised but in reality are not. However the perception they will be criticised possibly even disciplined or referred to the NMC, is a significant contributory factor that has a detrimental effect on their psychological wellbeing leading up to the internal review.

Many of the participants shared how their levels of anxiety were significantly heightened when they heard they were required to attend a coroners hearing. They described how this affected their psychological and emotional wellbeing including changes in behaviours such as sleep disturbance and loss of appetite. For some nurses these effects also impacted on how they functioned at work. These feelings of acute anxiety were often exacerbated by very lengthy delays before the court hearing commenced. Several health studies, predominantly non-nursing literature, make some reference to the stressful nature of attending court. An important difference that my study has found is they make no reference to identifying that for some, the anxiety is a constant and a mounting feature (Hodelet and Hughson 2001, Campbell and Fahy 2002, Pompili et al 2002).

The anxiety of attending the hearing was largely due to feelings of uncertainty of being accused of poor practice or neglect of duty. Nurses felt the court and the subsequent impact this may have on their career would leave them feeling blamed. These findings confirm non-health literature that identifies the emotional and psychological impact on staff when subjected to public scrutiny. Regehr et al's (2002) associates this with the all-consuming nature of inquiries and the feared criticism of personal and professional integrity.

Previously unrecognised in the mental health nursing literature my findings show that a protective factor for lessening the feelings of anxiety was the opportunity to prepare for the hearing well in advance. This would include an opportunity to discuss the hearing with senior managers and, when appropriate, the Trusts solicitors. Previous experience of attending a coroner's court was also of some help in that individuals had an idea of what to expect. However this was dependent on their personal circumstances, i.e. was the previous experience positive, is the pending case subjectively similar or worse. These factors would all influence how they felt about the case.

Previous experience was also relevant for nurse managers involved in the study. However they felt that they were less able to raise concerns as they felt there was a tacit expectation that they would be able to cope because of their seniority and experience. This finding is consistent with other studies that have identified that managers feel unable to publicly raise their own feelings of anxiety (Alexander et al 2001, Bennet et al 2004). A concern with this aspect is that senior staff who may be perceived to be 'coping' with the situation may actually be experiencing psychological distress. The distress may be a result of a single event or possibly due to the cumulative re-exposure to similar serious incidents (Robinson 1993). One of the participants who continued to have ongoing effects of the incident was a senior nurse manager. Whilst their level of psychological distress would be unlikely to meet a diagnosis of post traumatic stress disorder the findings of this study suggest that

continued exposure may increase the likelihood of developing PTSD in accordance with Stephens and Miller (1998).

Attending the coroners hearing was seen as the most stressful and professionally challenging aspect of the whole process. This finding confirms various studies that identify the stressful nature of attending court (Chemtob et al 1988, Pompilli et al 2002).

Fear of blame and professional repercussions was a significant stressor for participants in this study. This accords with other studies that recognised the highly stressful nature of the coroners hearing. The element of public scrutiny and the subsequent media attention has been prevalent in a number of studies. This is particularly evident in studies of the death of children (Hill 1990, Axford and Bullock 2005) where the expectations of the public is perceived by the workers that more could or should have been done to prevent the death occurring. Regehr et al's (2002) affirm the process can also risk re-traumatising the individual by having to publicly outline their involvement in the death. Further evidence of this can be seen in studies of the armed forces where personnel are held to account for their perceived failings (Shrader 1992, Hewitt 1992, McHoul 2007). My findings are in contrast to this and the view that in some cases the public need to be seen to have retribution for the incident is less obvious. Most participants viewed the coroner as trying to reach a fair and balanced conclusion. However, perhaps most closely correlating with the notion of a public inquiry, in cases where the family were angry or upset about the quality of care, this had a noticeable detrimental impact on the participants.

Some factors that were beneficial in reducing the anxiety and distress on the day are noteworthy. Many of the nurses fear of the court process was greater than the actual reality of the event. A number of the participants said that the coroner was extremely helpful in guiding them through their evidence in a way that felt constructive. They also identified that the support of a peer or manager was generally beneficial. Some

studies have suggested that staff have been critical of the lack of manager's support during the hearing (Regehr 2003, Connolly and Doolan 2007). The findings of my study suggest this was not evident at this final stage of the process. Perhaps the strongest view from staff about protective factors for during and post the coroners court was hearing an outcome from the coroner that was not critical or seeking to blame individuals. The nurses broadly accepted that their practice should be scrutinised by the coronial process and therefore hearing that they could not have prevented the death was felt to be extremely powerful. This accords with non-health based studies that have shown if the scrutiniser is not critical of individuals this validates their practice and enables them to psychologically move on from the case (Regehr 2003, Munro 2005).

6.3.7 Changes in clinical practice

Findings show how at specific time points or as part of the pervasive general anxiety, participants felt their clinical practice was affected in various ways. There were two principle areas that emerged namely record keeping and risk assessment / risk management.

The findings in relation to record keeping support other studies (Ruskin et al 2004, Tillman 2006). Nurses tended to adopt a more diligent approach to record keeping as part of a protective response to prevent a similar incident reoccurring. Participants expended considerable emotional and professional energy in ensuring that their notes were more detailed and demonstrated the relevant rationale for their clinical decision-making. This study differs in that some nurses suggested that as a response to the adverse effects of the death they had become more accomplished and diligent in their practice. Therefore whilst the impetus to provide more detailed accounts was borne out of a protective response, for some, it moved into a more positive experience.

One of the major changes in practice was how participants sought to manage clinical risk. They experienced an almost immediate change in practice to ensure other clients were safe. They affirmed that it was equally to reassure and protect them from possible re-exposure to a further death occurring. Such changes in clinical practice are well recognised in the literature and not unique to this study (Chemtob et al 1988, Valente and Saunders 2002, Gitlin 2006). Some of the participants echoed other studies in that risk assessment would become the sole focus of their work and would include, if possible, avoiding working with clients who were perceived to be a higher risk of harming themselves. Interestingly whilst this is well recognised in the academic literature, none of the participants seem to recognise this as a common experience. Therefore this potentially led to further feelings of isolation, compounding feelings of anxiety and distress.

The evidence from this study confirmed the nurses' practice would generally return to 'normal' with less indications of hyper-vigilance after a period of time. This varied from person to person but accords with other studies. Sun et al's (2005) literature review of the effects of suicide on nurses acknowledges a process of transition from the incident through to a return to pre incident levels of practice. Previously unrecognised in the mental health nursing literature, my findings identify that most participants cite the completion of the coronial process ultimately bringing closure and restoring their clinical practice to pre incident levels. This differed only if the experience of the nurse was less positive. The participants acknowledged that the process of the death and the subsequent scrutiny has led to a journey of personal reflection. Finally many affirmed their awareness of the responsibilities of being an independent and autonomous professional accountable for their own actions and/ or omissions.

6.3.8. Learning Lessons

Learning lessons from untoward events is seen as an integral part of providing contemporary health care services (NPSA 2008). In this study there was evidence from the nurses of personal learning and reflection on learning across the organisations. The personal learning centred on two main areas. Firstly participants had a heightened awareness about the technical element of their role in relation to clinical interventions and or judgments. This was most evident in areas such as keeping accurate and contemporaneous records and ensuring risk assessments and management plans were responding to the changing needs of the client. This area overtly reminded them of their responsibilities as a registered nurse and the accountability issues that the period of scrutiny exposes. Secondly and on a more personal note the process reminded them of the vulnerability of the client group and how this may mean clients may die.

Several of the nurses outlined that overall this had been a positive learning experience. However the majority reported that the death and subsequent process of scrutiny was the most difficult and stressful aspect of their career. My findings support Edrees et al's (2011) survey of 350 clinicians regarding support for second victims. They identify that individuals cite personal learning as an outcome but also express frustration at the lack of organisational support. Edrees et al's (2011) challenge organisations to develop more robust processes to support staff and learn from patient safety incidents. My study supports this view as the nurses identified that their respective organisations could have done more to prepare and support them through the process of scrutiny. Furthermore they suggested that organisations should further invest more in the preparation and support of staff through the inquiry process.

Participants from inpatient services more readily identified changes in the organisation that resulted from learning lessons from the incident. Community nurses

felt this was much more difficult to discern. Possible explanations for this could be that the view expressed by participants that organisations take inpatient deaths more seriously and thus commit more to learning. A counter position may also be that community services are much more disparate and therefore organisational responses may be more difficult to ascertain. Numerous studies and publications have affirmed the need for organisations to develop learning cultures (NPSA 2006, NPSA 2008, Wu et al 2012). This study supports this view but argues that the complexity of running large organisations still impedes the ability to demonstrate how lessons are learnt from serious events.

6.4 Description of key events and the development of a theoretical framework

Throughout the study participants discussed the impact the death had on both their professional and personal lives. Other international studies have outlined the immediate effects on nurses and describe various reactions including heightened feelings of anxiety, changes in clinical practice and feeling responsible for the death (Botega et al 2005, Cutcliffe et al 2006, Carlen and Bengtsson 2007). Valente and Saunders (2002) meta analysis of the impact on nurses following suicide suggests that the response of some nurses may be akin to a bereavement process. Collins (2003) and Tillman (2006) further suggest that the psychological and behavioural response may be similar to the bereavement process that is seen in the carers of the deceased. Literature on 'second victims' also argue that for some staff a bereavement process follows a serious event or error which leaves them experiencing grief like symptoms (Denham 2007).

Several non-health related studies have considered the impact of unexpected deaths, psychological trauma and professional scrutiny and identified some potential themes that emerge for workers. Regehr et al's (2002) suggest a number of areas that contribute to the distress of the employee. These include the personal trauma

experienced by the worker, through to the potential re-exposure to similar events at work and feelings of professional vulnerability. Several of these factors have been identified in the experience of participants within this study. Regehr et al's (2002) established how inquiries that follow child deaths can have a detrimental effect on child care social workers and argues that a different model of public assurance may be more beneficial in improving practice when this is required. Regehr's study, whilst establishing the impact on workers, the employers and the wider community falls short of identifying specific opportunities or times to reduce psychological distress. The findings of my study differ as I have identified some specific time points through the analysis of the experiences of the nurses.

Regehr et al's (2003) qualitative study of 11 police officers following a traumatic event and the subsequent public inquiry is important in understanding the experience of staff. They offer a thematic model that describes a process that police officers may experience following an incident. The model outlines how the police officer and their employers may react at different stages throughout the process. This includes the psychological impact on the worker, changes in their behaviours at work and the more personal consequences for the individual. This extends to how the incident infiltrates their family. This model is of significant interest in that it details some of the phenomena experienced by participants in this study and described previously above. However an important difference between the findings of this study and Regehr et al's (2003) is that they do not identify precisely when interventions may be most beneficial to the police officers. Their study clearly suggests areas for interventions but does not identify when to intervene.

Therefore what emerges from the consideration of my findings and the literature, including both the health and the wider professional enquiry and psychological trauma work is that this area is complex and multifactorial in nature. An important outcome of this study is the development of a theoretical framework that is informed by the data and enhances previous knowledge. The framework identifies a timeline

when staff are more likely to experience feelings of psychological distress. This has not been previously identified in the mental health nursing literature. The framework also identifies what mitigates or aggravates how the nurse responds. I also argue that the framework is transferable to other settings albeit the time points and relational factors may be different.

The framework (Figure 6.1) is developed around the four key time points set out below.

6.4.1. Time point 1-The incident and the aftermath

The evidence from this study combined with other literature suggests that the death of a client produces a range of psychological responses. These vary from feelings of acute anxiety, fear, guilt, sadness and in some cases anger. The level of intensity may be variable and will also, in part, be informed by how they became aware of the death. In mental health services this is ordinarily either directly (i.e. they dealt with the actual death usually in an inpatient environment) or indirectly (hearing the news through a third party e.g. police/ family). It is likely that as well as an emotional response the effects will include behavioural manifestations of psychological distress that may overspill into their home life.

Findings show that after the death a process of transition occurs. This is derived from the initial shock of hearing the news to the realisation of the potential consequences of the incident and the subsequent effect on the worker. From the nurses perspective this is clearly a critical point in determining how they may respond to what will be the ongoing process of coping with the death and the subsequent scrutiny. For those nurses who have not experienced a death before this provides an important opportunity to intervene and offer both psychological support and information.

From the perspective of psychological intervention it would appear that little weighting is routinely given to understanding the nature of the relationship when offering support to the nurse. When the nurse has a close emotional relationship with the client a greater recognition for support should be offered. This is not to say that in the absence of a 'significant relationship' that support is not required but the type of relationship may be an indicator for support and an opportunity to recognise and validate the emotional response of the worker. It is also clear that for the nurses involved recognition of this point would be both welcome and well received. A clear message from participants was the need for a greater sense of a personalised response from their employer. This approach would be tailored to meet the needs of the individual. An enhanced understanding of how the nurse felt about the client would provide a strong indication of what ongoing support may be beneficial.

Aggravating factors

- The type of relationship the nurse had with the client is an important factor to consider. Those nurses who express a close emotional connectivity with the clients are more likely to experience greater feelings of grief and loss.
- Staff who are not working in a supportive team environment where they feel more able to disclose their feelings.
- Previous experience of similar event that are perceived to have had an adverse effect on the individual.
- Distressing direct experience of trying to sustain the clients life (usually associated with inpatient services)

Protective factors

- Close supportive team
- Contact from senior managers inquiring after their wellbeing
- Access to tailored personalised psychological debriefing
- Access to support that is perceived to understand the experience of the nurse
- Support from senior clinically credible manager

6.4.2. Time point 2- Interactions with the family

Participants had various occasions when they might meet with the family members of the deceased. The rationale for the meeting varied from individual to individual however it was almost inevitable that they would meet with the family at some stage. These contacts with the family were generally seen as anxiety provoking. Even nurses who had a close relationship with the family prior to the death expressed significant concern about how the family may react to them after the incident. Many of the nurses attended the patients' funeral despite feeling extremely anxious about this. Meetings with the family were either voluntary support (e.g. the funeral) or as part of a professional or organisational requirement (e.g. attending the coroners hearing). Both types of interaction were stressful but those deemed to be an organisational requirement were more so.

Aggravating factors

- Hostile or angry family
- Informing the family of the death / breaking the news
- Providing feedback to the family on internal investigations
- Responding to families questions at court
- Family deem death preventable

Protective Factors

- Family accepting of death
- Family expressing gratitude for staff interventions
- Family expressing gratitude in involvement in internal investigation
- Family expressing no more could have been done

6.4.3. Time Point 3 - Internal scrutiny

The participants identified that the internal inquiry process was a key event in terms of significantly raising their anxiety about how both they and the organisation felt about the incident. This heightened anxiety would have a detrimental impact on them prior to attending the internal review. This manifested in a range of psychological and behavioural ways identical to other time-points. This heightened anxiety appeared to be unrecognised by their employer. Nurses in this study echoed the wider literature reporting that they feared they would be blamed or disciplined for any potential failings or omissions in the clients care. Nurses in this study also expressed their anxiety that they might be referred to the NMC.

Aggravating factors

- Previous negative experience of internal reviews
- Staff suspended whilst review taking place
- Lack of clarity between process of internal review and HR policies
- Perception of distant and uncaring management
- Personal and organisational feelings that the event was preventable.

Protective factors

- Expression by managers they have confidence in the skills of the nurse
- Support from peers and colleagues
- Evidence of organisational learning from previous events
- Sharing of findings with the individual
- Sharing with staff the event was not preventable

6.4.4 Time point 4 - Coroners hearing

The attendance at the coroners hearing was seen as the most stressful and professionally challenging part of the whole process. This is in keeping with various studies that identify the stressful nature of attending court (Chemtob 1988, Pompilli 2002). This final stage of the scrutiny process probably provided the biggest opportunity to ensure their staff feel psychologically prepared and supported for the hearing. When an outcome is reached that involves the coroner validating the practice of the individual, combined with positive comments from the family of the deceased, it appears to provide staff with a real opportunity to find closure. Paradoxically if the court is critical and or the family remain angry it is likely that staff will need to have continued psychological support after the case concludes. This final stage is particularly important as it enable staff to complete their recovery from the process of scrutiny.

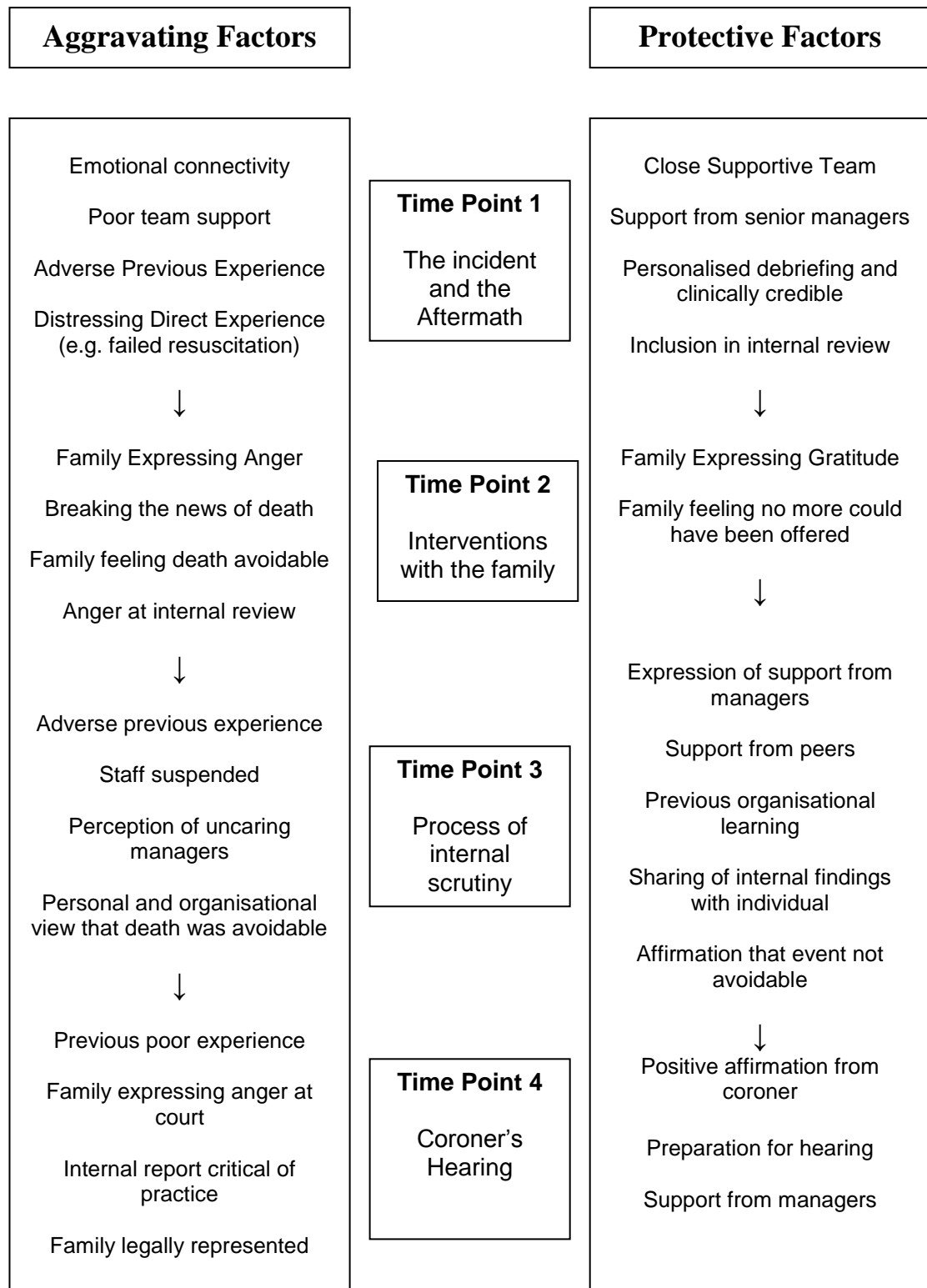
Aggravating factors

- Previous poor experience at court
- Hostile family at court
- Trust court report is critical of practice
- Family legally represented
- Practice criticised by the coroner

Protective factors

- Affirmation from the coroner that their practice was satisfactory
- Affirmation from the coroner that the death could not have been prevented
- Preparation for coroners hearing with senior managers and solicitors (if appropriate)
- Opportunity to visit the coroners court to see what it looks like
- Support from managers and colleagues during the hearing
- Adequate notice of the hearing date and opportunity to prepare

Figure 6.1 - Framework for key time points



The identification of the time points and the development of the framework alerts individuals and organisations to key events in relation to the experiences of the nurses. The benefits of the framework will be further outlined in the implications for practice section 6.6.

6.5. Summary of discussion and contribution to knowledge

This chapter identified that there are areas of similarities in this study when compared to existing literature on professional scrutiny and psychological trauma. It is clear that the death of a patient and the subsequent process of professional scrutiny can have an adverse effect on the psychological wellbeing of the individual.

In acknowledging the similarities the sections above also identified some areas within this study that have contributed to further knowledge. To summarise these are;

- The psychological response of participants is similar to studies on ‘second victim’ (Scott et al 2009, Wu et al 2012). An important difference lies in the concept of ‘error’. Nurses in this study did not express or indicate that they had made an error although did question their judgment in relation to ascertaining signs of risk
- The duration of symptoms sometimes associated with secondary trauma and second victim (Figley 1985, Collins 2003, Scott et al 2009) generally only manifested at key time points pertaining to stressful events. The symptoms were not routinely present at all times.
- There has been a paucity of studies exploring the effects of suicide on nurses. This study affirms the nurses’ experienced psychological distress similar to other non-nursing literature (Yousaf et al 2002, Gitlin 2006, Tillman 2006).
- Participants seemed less likely as a social group to have developed overt coping mechanisms that could facilitate a maladaptive change in behaviour

e.g. refusing to work with clients, desensitisation to other clients, becoming task/protocol orientated. (Clohessy and Ehlers 1999, Cassidy 1998, Gustavsson and MacEachron 2002, Wright et al 2006).

- Cognisant of non-nursing studies it is clear that the type of relationship the nurse has with the client is an important factor. However the findings from this study indicate that the emotional impact of the death is more determined by the nature of the relationship rather than professional group. This challenges previous perspectives on nurse relationships (Valente and Saunders 2002)
- Several health studies, predominantly the non nursing literature, make some reference to the stressful nature of attending court but make no reference to identifying that from the initial awareness of the hearing, for some the anxiety is a constant and a mounting feature (Hodelet and Hughson 2001, Campbell and Fahy 2002). Subsequently these studies do not identify that nurses would benefit from preparation for the hearing.
- Previous studies do not acknowledge that, for staff, they are not able to fully psychologically reconcile events until the coroners hearing has concluded.
- The exposure to families may be a point of extreme anxiety and stress for the individuals particularly when disclosing the death of a relative. The level of anxiety has not been overtly recognised in previous studies (Regehr et al 2002, Collins 2003, Kilshaw 2004).
- The experience of professional scrutiny and psychological consequences has previously been unrecognised in mental health nursing. Numerous studies cite that staff feel blamed for their actions (Chemtob et al 1989, Wright et al 2006, Foley and Kelly 2007). This study found that many nurses feel they will be blamed or criticised but in reality are not.
- Whilst the need to learn from adverse events is generally accepted (NPSA 2006, NPSA 2008, Wu et al 2012) this study found that only inpatient nurses could readily identify how their organisation had learnt from the death.

- The study has identified previously unrecognised key time points for nurses following a suicide or unexpected death. This enabled the development of a theoretical framework that illustrates the time points and factors that ameliorate or aggravate the response of the individual.

This study has identified, through the experiences of the participants, areas that further develop existing knowledge of psychological trauma and professional scrutiny. As part of developing theory and the analysis of existing literature it also became apparent that there is additional knowledge that potentially has implications for clinical practice. These implications are explored in the section below.

6.6. Implications for practice

This section considers what has emerged from both the findings and the analysis of existing knowledge and how this may inform practice. The time points outlined in figure 6.1 provide a potential framework to inform practice after an unexpected death or suicide.

Takahashi et al's (2011) suggest that, despite it being recognised that mental health professionals may be exposed to patient suicide staff, welfare and support mechanism remain inadequate. The need for greater interventions and support for staff has been affirmed in a number of national and international studies (Scott et al 2009, Sirriyeh et al 2009, Wu and Steckkeberg 2012). In the UK it is widely recognised the psychological and emotional wellbeing of staff have a beneficial effect on patient safety (Elfering and Grebner 2008, DOH 2009). These studies are of interest in that they recognise that there are psychological implications for staff that arise as a result of the death of a service user or untoward event. However they also recognise that further research is required and make only broad suggestions for what

may reduce the psychological impact on staff. They are therefore limited in that, whilst they identify the potential effects on staff, they do not specify at what time interventions could be offered to provide relevant psychological support. This study has identified key time points to support staff that have been previously unrecognised in the literature.

In the context of a clinical doctorate I felt it important to consider what information may lessen the experience of anxiety and stress the nurses described. This is an important aspect of this research, as many previous studies on nurses have not considered the whole process of the impact of the suicide and unexpected death (Valente and Saunders 2002, Gilje 2005, Takahashi et al 2011). Greatest support to staff was provided in the immediate aftermath of the incident. However this study has demonstrated that this is often insufficient and fails to adequately address the level of psychological support that staff require. This concurs with other studies that suggest more timely interventions to ameliorate the stressful, traumatic and challenging environments staff work in will have individual and organisational benefits in improving the psychological wellbeing of the workforce (Neveu 2008, DOH 2009).

A framework for recognising when psychological support and intervention are required begins to address the perception of a culture of blame (Appleby 2006). If organisations are able to demonstrate they have systems that understand and respond to the needs of their staff in circumstances that are deemed to be professionally highly challenging and personally difficult it may begin to shift perceptions of retribution and blame to one of fairness, support and transparency. An important finding was the perception from many of the participants was that their organisation had little understanding of the ongoing psychological and social impact on them. The framework outlined in figure 6.1 seeks to address this perception. It can act as a guide for managers and staff to key periods when intervention for emotional, social and psychological support may be beneficial. It also enables staff to recognise that

their feelings and responses are not necessarily unique. The framework offers guidance over factors that may provide aggravating or protective elements for staff. It is emphasised that this guidance cannot provide person specific information and individuals may have personal variables that interplay with the common denominators identified through this study.

Scott (2008) and Sirriyeh et al's (2008) affirm the importance of managers providing support and through this both the individual and organisation achieves greater learning from untoward events. Sirriyeh et al's (2008) also advises that this process can also aid personal recovery for individuals in receiving acknowledgment it was not their fault. I argue that the framework described above can enhance practice through the delivery of more timely support for staff.

6.7 Reflections on methods

This study was undertaken utilising the process set out in the methods chapter (Chapter 4). However it is an essential facet of this study to give consideration to any potential vulnerability. By understanding and acknowledging any methodological shortfalls I have ensured I remained able to respond effectively and accordingly to any potential methodological frailties. Some critics of the constructionist grounded theory approach argue that it relies too heavily on the participant's accounts and interpretations and subsequently does not pay sufficient regard to what is already known (McMahon 1997). In order to offset this potential problem, this study was subject to a process of continuous 'horizon scanning' for newly published literature. This provided additional rigour by ensuring the researcher was always cognisant of any pertinent published works. This process also ensured an iterative approach to the study. The research continually evolved and responded to the individual and collective categories and sub categories that emerged from the participants. I adhered to the approach of Charmaz (2000) and ensured that a richer understanding of the

participants' experiences was derived from my interaction with the study and the constant questioning of the data. Charmaz's (2008) perspective also enabled me to engage with the data rather than a rigid adherence to a theoretical framework that risked becoming detached from the social realities of the participants.

Thematic analysis, whilst having multiple strengths has the potential for weakness. Bryman and Burgess (1994b) suggest that the criteria employed in the identification of categories can be unclear and that it can have limited interpretative power beyond description. It has also been stressed that thematic analysis must be an inherent part of a theoretical framework or it can be vaguely applied and ill defined (Braun and Clarke 2006). This study is cognisant of these potential limitations. The research was undertaken within a recognised research paradigm that is mindful of the importance of qualitative studies being trustworthy and credible. This conscious process helped obviate any methodological criticisms.

The purposive sample was, given the nature of the study, the most effective way of identifying participants. However, a potential vulnerability with this sampling method is that it is difficult to mitigate against a level of self selection from the participants. I was aware of nurses who attended a coroner's court who did not feel willing or able to participate in the study. The rationale given was they did not wish to potentially re-expose themselves to any potential distress. Given the sensitive nature of this topic it is not uncommon in this area of research (Rassin et al 2005). The study endeavoured to adopt a sensitive approach to encouraging nurses to participate and the letter of introduction to the study was mindful of the sensitivities attached to this subject area. This particular area was subject to discussion at the Essex Local Research Ethics Committee (the approving ethics committee). The committee acknowledged that attracting recruits might be difficult. To this end they asked that the Director of Nursing from the relevant Trust extend a personal letter to potential candidates asking that they consider participating in the study. The

letter, whilst encouraging potential nurses to participate, very clearly emphasised that this was voluntary and thus permitted nurses not to participate.

A number of criticisms are often levied at qualitative studies, which suggest that the approaches are too subjective, difficult to replicate, the findings are subject to generalisation and they frequently lack transparency (Bryman 2004). Richardson (1998) suggests that these types of criticism have some potential truths and the researcher has an obligation to offset these criticisms by embedding their study in a sound theoretical and methodological framework that provide a clear and unequivocal audit trail. I remained vigilant to these criticisms and followed the proposed frameworks outlined above which mitigated against such general criticisms.

6.8 Implications for future research

An important element of this iterative process was to reflect upon what this study may mean for opportunities regarding future research. This study met the generally agreed requirement for sufficient numbers of participants to generate meaningful findings in a qualitative study. However, in isolation, this remains a fairly discreet piece of research. I am also mindful of areas that the study would have wished to explore in more detail but was necessarily limited due to the parameters of the Doctorate in Health Care. The nurses who participated in the study actively gave full accounts of their experiences. These collective experiences developed the relevant theories outlined above. Future work could also consider any particular similarities or differences between participants, notably whether factors such as gender, ethnicity and professional status have any bearing on individual or collective responses. I am cognisant of the potential for organisational cultures to potentially impact on the study. Organisation culture are clearly linked to staff views of blame *and fairness* (Appleby 2009). There were a number of nurses who would have met the involvement criteria but chose not to participate. One cannot assume why this might

be but further works may wish to consider is this due to individual circumstances, organisational overlay or concern of re-traumatisation.

Acknowledging this and cognisant of some of the findings I propose the following areas for consideration for further research.

1- The relationship between second victim research and error recognition in mental health professionals. Scott's et al's definition (2009) of second victim does recognise that the associated response of staff after an unexpected event goes further than if one is contained by a perception that the incident was as a result of an error. However the majority of studies of second victims appear to deal predominantly with the notion that an error has occurred. In mental health services it has been recognised that some deaths by suicide or those that are unexpected are preventable (Appleby et al's 2007). However, certainly in relation to most deaths in the community, the death of a client would not necessarily always be perceived to be as a direct error by a member of staff. This study has shown that the psychological effects on staff are similar to the studies on second victims. A further exploration of whether a perceived error has any further consequences on the psychological response on the mental health practitioner may be beneficial.

2- The theoretical framework for key time points. This study identified the development of a potential framework which could be used to support staff at key time-points in their journey from the death to the conclusion of the inquiry process. The proposed framework needs further development and refinement. The final process would ultimately require further research to test the appropriateness and rigour of the time-points. Equally, additional work needs to be undertaken to further validate the aggravating and protective factors outlined above. The framework proposed is based upon the experiences of the fifteen mental health nurses. It is also informed by the wider non-health literature on psychological trauma and professional scrutiny. The key time-points in this study are relevant to mental health practitioners.

However it seems likely, based upon the literature, that other non-mental health professional groups may have similar critical junctures where support may be beneficial. The area of critical time points for other professional groups may be worthy of further study.

I would argue that the two areas identified above would most obviously benefit from further study.

6.9. Conclusion

This study is important as it identified a number of areas that advance knowledge. Importantly it addresses gaps in the literature in relation to professional scrutiny and the psychological consequences of unexpected deaths and suicide in mental health nursing. This disparate set of works has provided an invaluable insight into what is known about the experiences of staff when someone dies in unexpected circumstances and who are then subjected to professional scrutiny. It acknowledges the studies on second victims and the similarities in the responses of staff. However I suggest that the concept of error is an important distinguishing feature and requires further research.

A key finding is a theoretical framework developed around significant time points for staff. These points could enable managers and clinicians a more timely and effective way of supporting staff at what has been deemed to be one of the most highly challenging and stressful events in the career of a mental health professional (Valente and Saunders 2002).

CHAPTER 7

CONCLUSION

This study was undertaken to build upon the existing knowledge of the consequences for mental health nurses following the death of a client and the subsequent process of professional scrutiny. It had been recognised that there was an absence of such research within the nursing profession. On developing the study I was drawn by much broader works that examined psychological trauma and professional scrutiny across a range of different professional groups. Whilst not obviously a homogenous group, they all bore the resemblance of experiencing scrutiny following an unexpected death or suicide of a client.

In order to fully understand the experiences of the participants within the group a qualitative study was favoured. Ultimately the research was undertaken using a constructionist grounded theory approach. This approach enabled theory development as participants shared their collective experiences. This iterative approach ensured the study responded to the narrative of the fifteen nurses who shared their experiences.

The findings of this study identified several areas that demonstrate the consequences of an unexpected death or suicide on the nurses. The participants all experienced varying degrees of psychological distress, which for two were similar to experiences more normally associated with traumatic stress disorders. The psychological distress would often transgress the nurse's professional lives into their home life. The study identified a number of areas that are likely to aggravate or mitigate the likelihood of experiencing an adverse psychological effect from an unexpected death or suicide. This led the development of a framework that may aid both managers and staff in the

understanding of the experiences of the nurse. The aim of the framework is for nurses to receive more timely support based upon likely events that they may find particularly stressful or anxiety provoking. Finally the study concludes with making recommendations for further research. The literature on second victims draws many parallels with the experience of the nurses within this study. In my view this is worthy of greater exploration that may further enhance the wellbeing of staff and arguably enhance quality and safety for the people we serve.

Appendix 1

Methodology for literature review

The search had two distinct elements. Given the nature of the inquiry a number of databases were searched to elucidate key texts for both suicide, psychological trauma for staff and professional scrutiny. To ensure that the review captured all available information in relation to published work no parameters were set in relation to time, date or language. Given the plethora of published work on suicide careful selection of key words was required. Key words had to appear in journal titles, abstracts or identified as a keyword by the original author. The key words included those areas that were felt most likely to produce the most relevant published literature (see Table A)

As part of the key word search Boolean terms, word truncation and wildcards were utilised to increase the likelihood of obtaining all data. Key words were combined with phrase searching and refinements to expand on relevant studies.

The following databases were searched:

- CINAHL
- Ovid Medline
- PsychInfo
- Web of Science
- Cochrane database for systematic reviews
- EMBASE

The database search was sensitive to possible variations in key words utilised by the relevant author to describe the same area of study. All relevant citations contained within articles were also searched to maximise cross checking of all available literature.

Table A – Keyword search

- Suicide
- Staff
- Response to and effects on
- Coroners court, coronial law and evidence
- Legal system and Witness
- Nursing
- Psychiatrists
- Mental health professional
- Psychologist and Therapist
- Psychological Trauma
- Second victim
- Professional inquiry
- Professional scrutiny
- Adverse event
- Social work
- Police services
- Emergency workers
- Armed forces

A number of key journals were hand searched from 2000 to date. These included;

- Psychiatric Bulletin
- Journal of Psychiatric and Mental Health Nursing
- International Journal of Nursing Studies
- British Journal of Psychiatry
- Journal of Advanced Nursing

Where articles were identified as helpful abstracts were read and for those considered appropriate a full text copy was obtained. A review of NHS policies pertaining to mental health services was also undertaken. (See table B)

Table B - NHS Policies and Mental Health Services

- | |
|---|
| <ul style="list-style-type: none"> • Department of Health (1998a) Modernising Mental Health Services • Department of Health (1999a) National Service Framework for Mental Health; Modern Standards and Service Models • Department of Health (1999a) Saving Lives • Department Of Health (2000d) The NHS Plan • Department of Health (2002) National Suicide Prevention Strategy for England • Department of Health (2007) Best Practice in Managing Risk • Department of Health (2008) Refocusing the Care Programme Approach
 • Department of health (2010) Equity and Excellence. • Cabinet Office: (2010) Building the Big Society. |
|---|

In addition, views from relevant individuals were obtained. These included informal discussions with a number of senior clinicians and managers working in mental health services and fellow Directors of Nursing. These discussions enabled greater insight into the effects of suicide on the role of mental health professionals. To enhance the information available discussions pertaining to the coronial element of the study, also took place with solicitors and barristers who specialise in representing NHS Mental Health Trusts in legal proceedings including coroners' hearings. Finally a local Coroner was contacted to seek their view on suicide, unexpected deaths and mental health professionals. This provided further invaluable insight both on coronial law and how mental health professionals fare when the give evidence at a coroners court.

Appendix 2

Draft letter from Director of Nursing

Date

Dear XXXXX

Re Invitation to Participate in Nursing research Study

The Trust has been approached to participate in a research study being undertaken by a researcher as part of a Professional Doctorate in Nursing at Kings University. The study is focusing on the experiences of mental health nurses who have attended a coroner's court following the possible suicide or unexpected death of a client they have worked with

I am writing to you as I believe you may be able to contribute to this study. I attach copy of the relevant information sheets that provide you with more detail about the aims of the study and how you can become involved. I would stress that this is entirely voluntary and you are under absolutely no obligation to participate.

I would ask that you do read the information sheet and consider whether you feel able to contribute to this study. If you are able to assist the researcher please can you contact him directly on the numbers provided.

Naturally if you have any specific queries that I may be able to help you with please do not hesitate to contact me.

Many thanks for your help.

Sincerely,

[Click **here** and type your name]

[Click **here** and type job title]

Appendix 3

Trust Head Office
99 Waverley Road
St Albans
Herts AL3 5TL
Tel: 01727 804866
oliver.shanley@hertspartsft.nhs.uk

Participant Information Sheet – Individual participant

An exploration of mental health nurses experiences of unexpected death or suicide
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Dear Colleague,

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully.

Please call me if there is anything that is not clear or if you would like more information.

Please take time to decide whether or not you wish to take part.

Part 1

What is the purpose of the study?

I am undertaking this research as part of a doctoral programme of study at the Florence Nightingale School of Nursing at King's College London and I am asking for your help.

Mental health services have seen unprecedented change over the last ten years. These changes have led to professional groups, notably doctors and nurses having to work outside of their traditional roles and boundaries, with a greater emphasis on safe and effective risk management. However even within services that have rigorous risk management procedures some authors suggest, on occasions people using mental health services will take their own lives or die unexpectedly. When such an event occurs it is generally a requirement for the internal review and a coroner hearing to be undertaken. Recently and reflecting the changes alluded to above, mental health nurses are more frequently asked to give evidence at these hearings. This role was once the sole province of the consultant psychiatrist. Some studies have identified the

professional and personal impact this has on doctors but little has been written about nurses and pay little attention to the impact of changes in role upon the nursing profession.

What I hope to do is explore, through individual interviews, the experience of nurses who have attended a coroner's court and consider the effects this had on them and their practice.

I will also be undertaking a series of focus groups across the health region with nursing managers. These groups will seek to gain their perspective on this change in role for mental health nurses.

Why have I been invited?

I am asking you to participate in this study as I believe you have attended a coroner's court in the last three years whilst working in either the community or in patient services. I am very interested in your perspective on this experience and want to know more about the impact of internal reviews and attending coroners' courts on mental health nurses. The study is being undertaken across a number of Mental Health Trusts within the East of England to facilitate a sufficient sample size and gain a regional perspective. The knowledge gained from the study can then be utilised for the professional development and education of the nursing workforce. I intend to interview mental health nurses who are currently working in the NHS. The interview will explore your experience of attending a coroner's court and what your experiences were pre and post the hearing.

Do I have to take part?

It is up to you to decide and you are under absolutely no obligation to say yes. I will describe the study and hope this information sheet will help you feel you have an important contribution to make to this study. I would then ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason.

What will happen to me if I take part?

The first thing I would do is seek your written consent to participate. You can take time to think this through and have about four weeks to consider this. You can also withdraw from the study at any time. I would then like to meet with you and discuss what your experience of attending a coroner's court was like. I would arrange to meet with you in a place and time that is convenient to you. Our meeting would take place in a room that is private and confidential.

The information you provide will contribute to the research findings. I estimate that I would need about one hour of your time. This would be a one off meeting. Our discussion would be recorded and I would then transcribe the contents of our meeting. This enables me to analyse our discussion in detail. I will also provide you with a copy of the transcript of the interview. If at any time you wish to withdraw from the study this is absolutely fine.

What will I have to do?

I do hope you are interested in participating in this study. Please call me on the number below to have a more detailed discussion about participating in the study.

What are the possible disadvantages and risks of taking part?

I hope that you did not find appearing at a coroner's court too difficult. It is possible that discussing this may remind you about this experience. Should this be the case I will ensure that you receive appropriate support through your Trust's confidential staff support services.

What are the possible benefits of taking part?

There may be no direct benefit in taking part however I hope that your experiences will help understand how the role of the nurse is changing in practice. Your experiences will enable an invaluable additional perspective for this study. The knowledge gained from the study can then be utilised for the professional development and education of the nursing workforce across the region. This will include that all participating organisations will benefit from learning from the experiences of their staff through the outcomes of the research findings.

What will happen if I don't want to carry on with the study?

As outlined above if you wish to withdraw from the study at any time this is absolutely fine even if it is after we have met. Any identifiable data regarding your involvement will be destroyed. Anonymous data provided by you will however still be used up until the time of your withdrawal.

What if there is a problem?

If you have any concerns about this study then please feel free to raise it with me at any stage. If you feel your concerns have not been appropriately addressed then you

may complain utilising the NHS complaints procedure. Details of this can be obtained from Trust Headquarters detailed above.

My employing NHS Trust, Hertfordshire Partnership NHS Foundation Trust is sponsoring this research and has appropriate arrangements in place to provide any relevant redress or compensation should you feel you have been harmed by this study.

Will my taking part in this study be kept confidential?

Interviews will be recorded digitally, anonymised and stored on a password protected computer. They then will be transcribed by the investigator. Participants will be provided with a copy of the transcript to ensure they feel it reflects the nature of the discussions. Can I reassure you that your information will be completely anonymous and all information is kept in a secure cabinet and password protected computer. It is also important to stress that any patient identifiable information should not be disclosed during the course of the interviews.

Interviews will be conducted within a private room conducive to the sensitive nature of the discussions at a location convenient for you. Interviews will take place during your normal working hours with express approval from your manager. The contents of our conversations will be completely confidential. The only circumstance that this would be breached is if you described serious malpractice or potential harm to yourself or others. In this unlikely event, full anonymity could not be guaranteed as I would be duty bound to disclose this in line with your Trust's reporting procedures.

All data will be stored in a locked cabinet or on a password protected computer with access restricted to the principle investigator only. The data will be completely anonymous and on completion of the study will be destroyed.

What will happen to the results of the research study?

This information will be used for me to complete my research thesis. I hope that the study will then be published in relevant journals. A copy of the completed research can be made available to you if you would be interested in this.

Who is organising and funding the research?

The research is being undertaken as part of Doctorate in Health Care I am completing at the Florence Nightingale School of Nursing and Midwifery at King's College London.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by Essex 1 Research Ethics Committee. The Study has also been approved by Hertfordshire Partnership NHS Foundation Trust.

Further information and contact details;

I hope that you feel that you would be willing to participate in this study. Please call me on the number below to discuss how you can contribute to this research.

Appendix 4

Individual Interview Guide

Introduction & Welcome

Hello my name is Oliver, thank you for meeting with me today. I received your consent form. I hope you found the information pack helpful. I also just want to remind you about confidentiality in case you were anxious about this. I want to spend about an hour listening to your experience of attending a coroner's court. If you want to take a break at any time, please just say. Have you got any questions or concerns before we start?

(Note: use prompts in *Italics* throughout to encourage more detail where appropriate)

Questions

- 1. Perhaps I could start by asking you to tell me a little about yourself, your role experience. What job were you doing at the time of the suicide /death and what did it involve? When was the incident? Has your role changed at all since then?**

- 2. Could you tell me a little about the actual incident & how you were involved?**

Had you known the client long and could you describe your relationship

How did you feel after the incident?

How did you behave after the incident?

What were you thinking about after the incident?

Did you feel any sense of responsibility or that you were somehow to blame?

Where you surprised by the incident or did you think something like this might happen

Is there anything that you think may have prevented the incident?

What happened after the incident, was there a internal review How did this review make you feel, think, behave

Can you describe how you were feeling at this stage, how did you cope with the experience? Did anything hinder you coping?

Did the event have any effect on you outside of work, can you share this with me?

What type of support did you receive e.g. from managers, meet with solicitors, counselling etc what was helpful? What could have improved this?

When did you know you where needed to attend court. How did make you feel etc

3. What happened when you attended court, how did you find this experience?

How long after the incident was the coroner court? How where you feeling in the run up to the hearing? How where you behaving?

How did attending make you think, feel, behave?

Ask about giving evidence, types of questions they were asked, how they found this. The types of coroners court e.g. jury, solicitors present for all sides

If you think back on the experience what would you recommend to others in a similar situation?

When you reflect on this experience did it have any effect on you? If so can you tell me what they were?

Did the experience make you feel any sense of responsibility or culpability for the event?

(THINK ABOUT WHAT MADE THEM COPE UP TO AND INCLUDING THE REVIEW/HEARING, IMPACT ON THOUGHTS FEELINGS BEHAVIOUR PHYSICAL SIGNS etc)

- 4. In mental health services much emphasis seems to be placed on risk assessment & risk management. Reflecting on your experience what are your views on this?**

Did any of this experience lead you to question your clinical practice at the time? Did you change at any stage e.g. after the event, after the hearing etc Did this experience influence your clinical practice now, if so how? Did you change? How?

Is there anything else about your experience that you would like to share or that you feel would be helpful learning for others?

Do you think the Trust learnt anything from your experience?

Did you learn anything from this experience?

Conclusion

Interviews Concludes. Ascertain participant is feeling able to leave the interview.

Remind as appropriate about local support systems should they need it. Advise that they will get a copy of the transcripts & reaffirm confidentiality.

Appendix 5 **Example of Theory development and Transparency.**

“ My line manager talked to me, did I need any extra support. I think it would have affected me more if I’d had a deeper understanding and I’d had a longer relationship with him. Kind of working in this field, you come to expect to lose some clients, not necessarily through suicide, but through overdose and things like that or accidental overdose. It was upsetting and shocking but I was able to deal with it.

Can you tell me a bit more about that, what you mean when you say the nature of your relationship and also for some clients you would expect it?

I tried to engage the gentleman, he would come in and he wasn’t one for talking really. He used to come in, do urine sample. We would talk about his drug and alcohol but I think because it was a fairly new relationship, it **was still building the foundations of that therapeutic relationship**, so I didn’t really know him that seriously and he didn’t know me so perhaps it was about when I know you a bit better I might disclose more...and things like that so that’s what I mean by that.

You said about reflecting on your own practice, how did you do that and what was your conclusions?

I think really I looked at whether I had, from a risk management point of view, I had **done everything**. As far as I can remember there wasn’t anything on his care plan we identified no risk. He was probably quite streetwise and could look after himself. When we used to talk about overdosing on his drug use, alcohol and crack, he was aware of the risks and I think it **wasn’t really until the coroner’s court at the end when he’s said that we’d done everything, then that was my closure because obviously that’s what was worrying me the whole time. It’s hanging over you because it’s your registration.**

Tell me about that experience when you said it's hanging over you.

Well, you know, you can't put it to rest and you know that this event is looming. I felt that I had done everything, my managers and everything said we think you've done everything, but it's a worry. He was still on my case list. The case wasn't closed and I had to do the report and then that went backwards and forwards several times.

Was that the report for the coroner?

Yes. It went to our legal department here then it came back to do a bit more, and tweak it. *So there was a lot of work from that point of view, so it was difficult to know how to get closure until we'd had the inquest.*

Did that time period from when it happened to closure, did any of that experience impact on your clinical practice?

I think I was far more cautious and probably the clients that presented who were depressed or were disclosing that they felt suicidal I think that *probably played on my mind more. Normally I had been able to at 5 o'clock go home and know that was my work day finished. So I think that's pretty natural that I had a heightened anxiety after an event like that.*"

(Participant 001)

Code

Red text = importance of relationship

Light Blue = risk management and clinical practice

Green = coroners court and links to psychological closure

Pink = fear of impact on nursing registration

Blue = Impact on self and clinical practice

Orange = Impact on wellbeing.

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